North Carolina
Health Care Reform Commission

ANNUAL REPORT

April 1996

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North Carolina Health Care Reform Commission

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Zeno L. Edwards, Jr., Co-chair

James G. Jones, M. D.
Executive Director

April 4, 1996

To: The Honorable James B. Hunt, Jr., Governor of North Carolina
The Honorable Marc Basnight, President Pro Tempore of the Senate
The Honorable Harold J. Brubaker, Speaker of the House of Representatives
Members of the 1995 General Assembly

The North Carolina Health Care Reform Commission herewith submits to you for your consideration its findings and recommendations pursuant to North Carolina General Statute 143-612A (f).

Respectfully submitted,

Carmen Hooker A.R.H.
Ms. Carmen Hooker

Zeno L. Edwards, Jr. A.R.H.
Representative Zeno L. Edwards, Jr.

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Locust, NC

Representative Jerry C. Dockham
Denton, NC

Representative Theresa Esposito
Winston-Salem, NC

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Table of Contents

Table of Contents

EXECUTIVE SUMMARY

Chapter 507, Section 23A.3; House Bill 230; General Statute 143-611 creates the Health Care Reform Commission. This action changes the name, membership, and leadership of the North Carolina Health Planning Commission, which had been established by the 1993 General Assembly.

In accordance with these changes, co-chairs of the Commission were appointed by the presiding officers of the House and Senate. Appointed to these positions were Rep. Zeno L. Edwards, Jr. and Ms. Carmen Hooker, respectively. Dr. James G. Jones continued as executive director of the Health Care Reform Commission.

Commencing November 8, 1995, the Commission has met at monthly intervals to address a variety of issues that fall within the scope of duties assigned by the General Assembly and Legislative Research Commission. The detailed agendas of these meeting are included in the appendices of this report. All meetings were open to the public and were well attended.

It is clear from the action of the 1995 General Assembly that there is no legislative desire for the State of North Carolina to proceed toward comprehensive health care reform. Rather, the state legislature prefers the market-driven approach to health reform and directs the Commission to monitor those changes in the health care delivery systems in the state and to advise the General Assembly and Governor regarding ways health reform may best serve the needs of the citizens of the state.

At one of its early meetings, the Commission adopted the following mission statement: "The North Carolina Health Care Reform Commission was created by the 1995 General Assembly as an independent body to monitor, evaluate, address, and study a variety of issues relating to the rapidly developing changes in the health care delivery system in North Carolina. With the goal of improving the health status of all North Carolina citizens, the Commission is expected to provide members of the General Assembly and the Governor with adequate data, recommendations and proposals to draft public policy across an array of services in the areas of access to quality health care, cost of health care, and the uninsured and underinsured citizens of the state."

While this annual report is submitted in accordance with statutory requirement, it should be viewed as a work in progress.

What should be evident from this report is that the health care industry in North Carolina is undergoing dramatic change. As reflected in the report, the current reform in health care is driven principally by three powerful issues of cost of health care, the number of uninsured people in the state, and access to care. These three topic areas have established the priority of the Commission as it responds to the daunting challenge of assisting the General Assembly and the Governor in crafting public policy that assures every citizen of the state access to high quality health care at an affordable price.

In the area of cost containment, the Commission has discussed strategies relating to medical savings accounts, fostering the development of integrated health delivery networks, managed care and the development of the small business purchasing alliances.

Having nearly one million North Carolinians who are uninsured and another million with inadequate health insurance, the state has a major threat to the health status of nearly one-third of its population. Repeatedly studies have shown that uninsured/underinsured people have poorer health and enter the system at a point in time and place so as to add significant cost to the overall health care price. These additional costs are passed along to all of us as hospitals and physicians shift these uncompensated expenses to those who pay. The availability of these "cost shift dollars" for service to the uninsured is disappearing as the quantity purchasing power of managed care plans and large employers drives providers revenues down.

The state through its Medicaid program has made valiant efforts to pay for the health care of the poor people in the state. The much publicized budget debate between the President and Congress has potential for playing havoc with this source of health care financing. The General Assembly has appointed a Blue Ribbon Task Force to study the implications of Medicaid cuts on the state budget. This Commission has been asked to work closely with that Task Force, and the collaborative efforts are presented in this report.

Several specific issues were referred to the Commission by the 1995 General Assembly in its special studies bill and the Legislative Research Commission. These include the state immunization program, fees for copies of medical records, chiropractic care, and emergency medical services. Each of these issues will be addressed in this interim report.

Finally, the Commission has developed some specific recommendations it wishes to have considered by the 1996 General Assembly. These are presented at the conclusion of the report.

STATUS OF HEALTH REFORM IN NORTH CAROLINA

Chapter 507, Section 23.A; House Bill 230; General Statute 143-611 creates the Health Care Reform Commission. This action changes the name, membership, and leadership of the North Carolina Health Planning Commission, which had been established by the 1993 General Assembly. The Health Planning Commission was designed to examine the feasibility of creating universal health care in North Carolina. The Health Care Reform Commission adopted the following mission statement at its December 14, 1995 meeting:

> The North Carolina Health Care Reform Commission was created by the 1995 General Assembly as an independent body to monitor, evaluate, address, and study a variety of issues relating to the rapidly developing changes in the health care delivery system in North Carolina. With the goal of improving the health status of all North Carolina citizens, the Commission is expected to provide members of the General Assembly and the Governor with adequate data, recommendations and proposals to draft public policy across an array of services in the areas of access to quality health care, cost of health care, and the uninsured and underinsured citizens of the state.

The Commission has met five times and heard testimony about several issues including costs, uninsured and access. While addressing these issues, the Commission feels that it is important also to emphasize personal responsibility for improved health status and to optimize quality of service. The current status of these issues is vital to the understanding of health policy considerations in North Carolina.

COSTS

In 1996, the total amount spent on personal health services was $21.7 billion, or $3,045 per person. By far, the largest portion was for hospital care at $8.9 billion in 1996 or a per person cost of $1,260. Spending for hospital care totaled 36.7 percent of the total amount spent in 1996 compared to 39.5 percent in 1986. In 1996, health care spending represented 13.1 percent of per capita income, a figure which, although slowing slightly in the last decade, has been climbing at a rate of 2.5 percent annually since 1966.

In addition, while per capita spending is lower in North Carolina compared to the rest of the United States in nearly all categories of service, this "margin of advantage" has declined significantly in nearly every service category.

The following two pages graphically display cost and spending information for North Carolina.

Trends in Health Spending
North Carolina, 1966-1996

Type of Service	Per Capita Spending, by Calendar Year 1966	1976	1986	1996	1996 Total (millions)	Annual Change 1966-1996	1986-1996
			North Carolina				
PERSONAL HEALTH	$ 143	$ 461	$ 1,307	$ 3,045	$ 21,734	10.7%	8.8%
Hospital Care	57	201	576	1,260	8,989	10.9%	8.1%
Physicians' Services	33	97	278	626	4,467	10.3%	8.4%
Dentists' Services	9	32	74	134	956	9.3%	6.1%
Other Professional Services	4	9	53	202	1,440	14.3%	14.4%
Drugs/Medical Sundries	25	67	167	330	2,355	9.0%	7.1%
Eyeglasses/Appliances	5	12	23	42	298	7.4%	6.2%
Nursing Home Care	6	30	98	275	1,961	13.3%	10.9%
Home Health	Included in Other		14	102	726	22.0%	22.0%
Other Health Services	4	12	25	76	543	10.3%	11.7%
OTHER HEALTH SPENDING	24	62	152	359	2,561	9.5%	9.0%
Administration	7	18	58	168	1,202	11.0%	11.3%
Public Health	3	13	43	94	670	12.3%	8.1%
Research	6	13	27	52	369	7.5%	6.6%
Construction	8	19	24	45	321	6.1%	6.6%
TOTAL HEALTH SPENDING	$ 167	$ 523	$ 1,459	$ 3,404	$ 24,295	10.6%	8.8%
			Percent Distribution				
PERSONAL HEALTH	85.8%	88.1%	89.6%	89.5%	89.5%		
Hospital Care	34.2%	38.5%	39.5%	37.0%	37.0%		
Physicians' Services	19.9%	18.5%	19.1%	18.4%	18.4%		
Dentists' Services	5.5%	6.2%	5.1%	3.9%	3.9%		
Other Professional Services	2.2%	1.8%	3.6%	5.9%	5.9%		
Drugs/Medical Sundries	14.7%	12.8%	11.4%	9.7%	9.7%		
Eyeglasses/Appliances	2.9%	2.3%	1.6%	1.2%	1.2%		
Nursing Home Care	3.9%	5.7%	6.7%	8.1%	8.1%		
Home Health	NA	NA	1.0%	3.0%	3.0%		
Other Health Services	2.4%	2.3%	1.7%	2.2%	2.2%		
OTHER HEALTH SPENDING	14.2%	11.9%	10.4%	10.5%	10.5%		
Administration	4.4%	3.3%	4.0%	4.9%	4.9%		
Public Health	1.7%	2.5%	3.0%	2.8%	2.8%		
Research	3.5%	2.5%	1.9%	1.5%	1.5%		
Construction	4.6%	3.5%	1.6%	1.3%	1.3%		
TOTAL HEALTH SPENDING	100.0%	100.0%	100.0%	100.0%	100.0%		

Note: Administration includes net cost of insurance administration plus administrative costs of public programs such as Medicare and Medicaid.

Source: Historical data obtained from Health Care Financing Administration

Source: Chris Conover, Duke University Center for Health Policy Research Education (684-8026)

Relative Health Spending
North Carolina, 1966-1996

Type of Service	Calendar Year 1966	1976	1986	1996	Annual Change 1966-1996	1986-1996
SPENDING BURDEN						
Per Capita Income	$ 2,326	$ 5,471	$ 12,462	$ 20,732	7.6%	5.2%
Personal Health % Income	6.2%	8.4%	10.5%	14.7%	2.9%	3.4%
Total Health % Income	7.2%	9.6%	11.7%	16.4%	2.8%	3.4%
	Relative Spending Index (US = 100)					
PERSONAL HEALTH	71.3	76.2	76.7	86.8	0.7%	1.2%
Hospital Care	71.6	72.8	77.7	89.4	0.7%	1.4%
Physicians' Services	70.7	76.5	71.8	80.5	0.4%	1.1%
Dentists' Services	60.8	74.8	77.1	80.3	0.9%	0.4%
Other Professional Services	62.3	64.2	65.6	79.8	0.8%	2.0%
Drugs/Medical Sundries	87.9	111.5	96.5	100.3	0.4%	0.4%
Eyeglasses/Appliances	72.9	78.2	73.4	78.6	0.3%	0.7%
Nursing Home Care	53.9	56.9	69.9	87.5	1.6%	2.3%
Home Health	NA	NA	52.4	87.3	5.2%	5.2%
Other Health Services	63.8	76.3	88.2	85.1	1.0%	-0.4%
OTHER HEALTH SPENDING	71.3	76.2	82.4	86.8	0.7%	0.5%
Administration	71.3	76.2	82.4	86.8	0.7%	0.5%
Public Health	71.3	76.2	82.4	86.8	0.7%	0.5%
Research	71.3	76.2	82.4	86.8	0.7%	0.5%
Construction	71.3	76.2	82.4	86.8	0.7%	0.5%
TOTAL HEALTH SPENDING	71.3	76.2	77.3	86.8	0.7%	1.2%
SPENDING BURDEN						
Per Capita Income	78.1	82.3	85.0	90.4	0.5%	0.6%
Personal Health % Income	91.3	92.6	90.2	96.0	0.2%	0.6%
Total Health % Income	91.3	92.6	90.9	96.0	0.2%	0.5%

Source: Chris Conover, Duke University Center for Health Policy Research Education (684-8026)

THE UNINSURED

A detailed report on the numbers of uninsured can be found elsewhere in this report, however, the number of uninsured currently is slightly under one million of the state's some 7 million citizens. There are a full set of specific problems which face the uninsured in this society. They have a hard time getting preventive care. They cannot pay for hospitalization when it is needed, and the cost of that unpaid care is passed along to all other paying patients, including government and taxpayers. The June 1995 figures, from the Prospective Payment Assessment Commission, for our state indicate that the cost-shift reflected in hospital bills is now 47 percent--that is private patients pay 47 percent more than their actual costs for hospital care in order to cover the cost of unpaid care. The magnitude of this "cost shift" is equal or greater in North Carolina than in all but six other states. The four higher states are Florida, Delaware, South Carolina and Mississippi. The states that are equal are Vermont and Nevada.

This link between the uninsured and increasing cost of care is one of the primary reasons government is involved in health care reform. Our system of providing health care coverage through the work place has failed to meet the needs not only of the uninsured but also of the underinsured. This system failure was and remains a driving factor behind health care inflation and along with poor lifestyle choices contributes to the poor health status of our population. In addition, in our era of economic downsizing, it is often an unspoken fear of the working population. When businesses and governments downsize, displaced workers also lose their health care benefits. If those workers are unable to pay their premiums on their own, they and their families are likely to become part of the uninsured, underinsured or Medicaid populations.

ACCESS

There is a growing perception that there is a serious oversupply of physicians in the United States and that oversupply is concentrated among specialists and in many urban areas. The spread of managed care and integrated systems has created a growing demand for primary care providers nationally and in North Carolina. North Carolina has areas of the state where there are severe shortages of primary care physicians and providers and other areas where existing providers are experiencing heavy demand.

The four medical schools, their affiliated primary care training programs, the statewide Area Health Education Centers system and the Office of Rural Health, with the support of the General Assembly, have expanded programs to increase supply and have created support systems to retain primary care providers in the state. However, the market for primary health professionals functions at a national level and North Carolina, alone, cannot fully meet the needs of the total underserved population without very strong policy changes that would seriously modify the market.

Estimates based on existing demand for services, and accounting for expansion of the managed care market, show that North Carolina has an immediate shortage in underserved areas of a minimum of 100 primary care providers. With continued expansion of managed care in the state, this shortage will grow to as high as 800 providers by the year 2010.

Options presented to the Commission for consideration (which should not be construed as recommendations of the Commission) include expanding existing training programs for primary care, assisting the transition of specialists into primary care practices, providing continued or expanded support for community-based primary care professionals, modifying the licensing laws to require practice in underserved areas prior to full licensure, and adapting the licensing laws to allow for network or institutional control over practice scope.

THE SYSTEM

The health care system in North Carolina is currently engaged in market-based, self reform founded in the discount purchasing model of managed care organizations. North Carolina has moved into this model of care provision at a more deliberate pace than other states in the nation. This is due in part to the fact that North Carolina's population is relatively evenly distributed geographically across the 100 counties, as opposed to a heavy concentration in one or two large metropolitan areas. As a result over half of North Carolina's population lives in predominately rural counties, 65 of which have been declared in whole or in part as health professional shortage areas by the federal government. This number is derived by the federal government by looking at the ratio of primary care providers to population. Anything greater than one to 3,500 is considered a health professional shortage area. There are some regions of our state with a ratio of one primary care practitioner to 16,000 people.

There are areas of North Carolina in which health care is simply not available to those who do not have transportation to other locations for care. Some parts of North Carolina's population, particularly the disabled, the elderly, and those for whom English is not their first language, have additional barriers to care. Some are complicated cultural and linguistic barriers; some are as simple as adequate transportation and child care availability.

The health care system is undergoing careful self-examination and market-driven change. Currently such innovative concepts as medical savings accounts, purchasing alliances, integrated systems and seamless continuum of care are being examined and attempted as the health care system transitions towards its future identity. The NC Health Care Reform Commission is engaged in a careful study of many different aspects of the health care system in an effort to make sure that unnecessary road blocks to creative change are removed while adequate consumer protection remains in place.

I. COST CONTAINMENT

In addressing the North Carolina Health Care Reform Commission at its first meeting in November, Dr. Jones, executive director of the Commission, said that with the failure of comprehensive health care at both national and state levels, it was clear that we would not have sweeping health care changes, but that North Carolina could still have affordable and quality health care.

Dr. Jones continued by saying that instead of government directing and dictating health matters, he believes the wise approach is through market reform—letting the market determine how health care will be delivered. He said that clearly on the national level, managed care has been the way to go. However, in North Carolina the problem of rural areas remains for developing managed care.

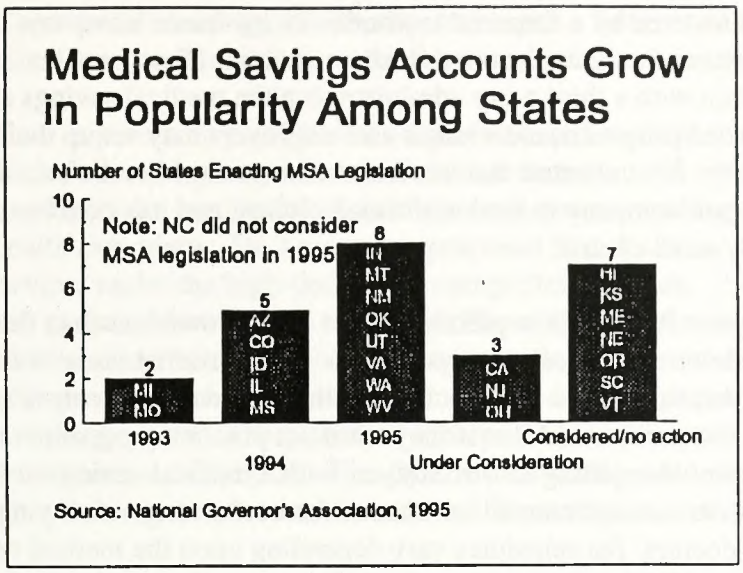
There are fifty states and fifty different approaches to health care reform - each tailored to the unique social, geographic, economic and political climate of the state. Like North Carolina, most states are allowing the restructuring of the market place to guide their health care reform efforts. The market is becoming prevention and primary care centered and also an intensively managed health care system. In conjunction with the market restructuring, the Health Care Reform Commission studied or began studying several issues that impact on cost. Those were medical savings accounts, managed care, integrated networks, the availability and affordability of small business insurance, and public purchasing.

I. COST CONTAINMENT

A. MEDICAL SAVINGS ACCOUNTS

At its January 24, 1996, meeting, the North Carolina Health Care Reform Commission examined the issue of medical savings accounts. Presentations included the national perspective, the North Carolina medical savings account plan under development by the State Health Director, and the managed care perspective.

Medical savings accounts with tax benefits are being developed as a potential tool for controlling cost increases and expanding access. Fifteen states have legislation governing medical savings accounts. Ten others are considering it.



Most proposals match the medical savings account with high-deductible catastrophic health insurance coverage. The premium savings for the high-deductible health insurance coverage are deposited by the individual or employer in the medical savings account. The account is the property of the covered individual and is allowed to grow tax-free. During the year, the individual may withdraw money without penalty to pay eligible medical expenses, and at the end of the year, the remaining funds can be withdrawn subject to income tax or rolled over tax-free for future health care expenses. In theory, medical savings accounts should reduce health care costs and utilization because the high-deductible, combined with the individual's ability to keep medical savings accounts money not spent, should provide a double incentive for less consumption of discretionary health care, thus lowering current health spending. (EBRI July 1995, Vol. 16 Number 17)

NATIONAL PERSPECTIVE

The national perspective on medical savings accounts was presented by Mr. Jack Strayer, Director of Federal Affairs, Council of Affordable Health Care and Mr. Dan Perrin, Executive Director, Business Coalition for Affordable Health Care. Mr. Strayer said that medical savings accounts are the only health care plan being discussed that will actually reduce the cost of health care and also have first dollar coverage and will, if properly drafted, provide a nest egg for later years. Mr. Perrin stated that medical savings accounts will have a greater significance in the economy than simply paying for health care since the accounts can serve as a base of wealth creation and increase the savings rates in this country.

Mr. Perrin said that safeguards against fraud are inherent in medical savings accounts because the person would essentially be stealing from him or herself and also insurance companies would be processing fewer claims in which fraud would be more readily obvious. Also, in most cases the insured does not have direct access to the

account since it is administered by a financial institution or insurance company. Mr. Strayer reported that actuarial studies show a reduction of about 20 percent in administrative costs, even with a third party administrating the medical savings account. However, with self-funded programs, individuals and employers may set up their own plan without a third party. He indicated that administrative savings accrue because it is expensive for an insurance company to deal with small claims, and it is cost beneficial not to have to deal with small claims.

Mr. Perrin said that figures show premium costs have grown less than the rate of inflation or have gone down in medical savings account programs that are at least five or six years old. He said that this would indicate the employees have not incurred sufficient expenses to meet their deductibles and that if they were not practicing preventive care, this would not be the case. According to Mr. Strayer, with a medical savings account the incentive to get preventive care is financial because of the cost savings of staying healthy. Mr. Strayer stated that doctors' fee schedules vary depending upon the method of payment, and doctors would rather deal with cash. In the event of a continuing catastrophic illness, each year new deposits in the medical savings account could be used to meet the annual deductible, and then the insurance would cover allowable health care costs for the remainder of that year.

NORTH CAROLINA MEDICAL SAVINGS ACCOUNT PLAN

Chapter 418, Senate Bill 525 directs the State Health Director to develop a medical and health care plan for persons whose employers pay all or part of medical and health care costs for their employees that includes provisions for long term care and may contain a medical and health care savings account. There are three steps outlined in the legislation. First, the State Health Director shall submit the minimum requirements for the plan to the Commissioner of Insurance. Second, the Commissioner will prepare and submit a proposed plan incorporating the minimum requirements to the State Health Director. Last, after consultation with the Department of Revenue, persons representing the views of physicians, hospitals, health insurance companies and health maintenance organizations and other necessary agencies, the State Health Director shall submit a final plan on the first day of the 1996 Session.

Ms. Janet Ramstack, representing Dr. Ronald Levine, State Health Director, updated the Commission on the requirements of medical savings accounts in response to the mandate of ratified Senate Bill 525. Ms. Ramstack detailed the process that led to the development of the medical savings account requirements that have been submitted to the Department of Insurance. Dr. Levine decided to include the Department of Revenue, persons representing the views of physicians, hospitals, health insurance companies and health maintenance organizations and other necessary agencies in the initial discussions to ensure all interests were addressed upfront.

From a series of meetings, Dr. Levine developed a final set of requirements and sent them to the Commissioner. Summarized below are the requirements.

The final requirement provides for employer-based medical savings accounts linked with high-deductible comprehensive health insurance as an option for health care coverage. Employers are required to assist their employees in making "value-based" choices for health care plans. Dr. Levine has proposed first dollar coverage for preventive services under the high-deductible comprehensive plan. Preventive services will be defined as those identified by the Health Planning Commission Benefits Committee. The account is transferable from one employer to another with a comparable plan and can be used to purchase health care insurance during a period of unemployment or applicable waiting period. The plan shall incorporate consumer safeguards with regards to administration of the plan. Finally, the plan shall provide for equitable tax treatment within the context of revenue needs and fiscal impact on the State.

Tom Jacks, Deputy Insurance Commissioner, presented the plan elements for development of MSAs and then gave an evaluation of the strengths and weaknesses of MSAs. Mr. Jacks indicated that the Insurance Department is preparing a plan in accordance with Dr. Levine's requirements. Medical savings accounts would be voluntarily offered by employers, and employees would volunteer to participate. Individuals and small employers (less than 50 employees) are not eligible. He said that the reason the MSA recommendations are employer-based is because of the wording in the bill. Mr. Jacks stated that revenue consequences and revenue loss are much greater if individuals are allowed to set up their own MSAs. He further suggested that to encourage employers to offer health benefits and strengthen the employer-employee relationship, it makes sense to have the plan employer-based. When asked if the department has looked at the option to make other recommendations for a change within the legislative mandate, such as allowing an individual or self-employed person to establish an MSA on behalf of himself and his family, Janet Ramstack said that at the time Dr. Levine reports to the Legislature he will have the opportunity to address other issues and will do so.

An option, but not a requirement, will allow employees to make additional contributions to the MSA. Adverse selection when an individual moves from a MSA to traditional insurance in anticipation of medical needs will be addressed by limiting frequency of changing between MSA and traditional plan to one time per year. Interest on MSAs is tax exempt while it remains in the account or is used for an allowable purpose. The legislation references that one-half the interest may by paid to the state to fund indigent care but that issue will not be addressed in the requirements because it is a revenue issue.

Mr. Jacks indicated that it is difficult to make accurate assessments about the strengths and weaknesses of MSAs because such accounts have a short history, thus limiting availability of objective evaluations. The degree of cost control depends on how account holders view MSAs. If seen as savings accounts, utilization and cost may be controlled. If viewed as another type of health insurance, there may be no impact on

utilization or costs. Access to health care services may be enhanced since more employers may offer health insurance because high-deductible policies are cheaper than low-deductible policies. On the other side, access may be limited by increasing premiums for sicker patients who remain in traditional plans. MSAs may provide incentives to delay needed primary and preventive care until more expensive medical treatment is needed. MSAs may encourage cost competition among physicians and hospitals by the development of new procedures and technologies that reduce cost.

MANAGED CARE PERSPECTIVE

Mr. Harry Kaplan, Government Relations Representative for Kaiser Permanente, presented the managed care perspective of MSAs to the Commission. Mr. Kaplan stated that MSAs are here to stay and that there are many good qualities to them. He said that the jury is still out on whether costs would go down. Mr. Kaplan also said that choice of providers is limited if an MSA is linked to something like a preferred provider organization. He further indicated that MSAs and similar plans were not on the same playing field as the traditional insurance companies that have mandated benefits. In order for managed care plans to participate in MSAs, rules will have to be modified.

At the February 28, 1996, meeting, the Health Care Reform Commission passed a resolution supporting the concept of medical savings accounts as an alternative source of funding for health care and recommending that legislation be introduced authorizing the establishment of medical savings accounts.

I. COST CONTAINMENT

B. NORTH CAROLINA HEALTH MARKET TRENDS - INTRODUCTION

The American health care delivery system is changing rapidly due to changes in the market place. North Carolina like most states is allowing the restructuring of the market place to guide its health care reform efforts. The market is becoming prevention and primary care centered and also an intensively managed health care system.

Managed care systems are designed to enhance the health of the patients through greater coordination of care, increased emphasis on prevention and primary care, and lower health care costs through the elimination of unnecessary services. Pressures to control costs have led to the proliferation of both private and public-sector managed care plans in recent years. North Carolina has moved more deliberately than other parts of the country, where managed care is more deeply entrenched. Almost all managed care in North Carolina is confined to major urban areas.

What is managed care? It is a generic term applied to several different health care systems. Managed care is a system which helps manage the patient's care--to ensure that the patient is receiving the most appropriate, usually most cost-efficient form of care. It

includes primary care case management programs in which a primary care provider is paid a monthly fee to manage the patient's care and act as the patient's gatekeeper, but then is paid on a fee-for-service basis for the care provided and has no financial risk for referrals (i.e., specialists are paid separately on a fee-for-service system). Preferred provider organizations, (PPOs), are also considered managed care, because the insurance carrier or health plan manages the costs by contracting with cost efficient providers. Patients can choose from the network of providers or any other provider, but pays more out of pocket for using a provider who is not part of the network.

The more traditional managed care entities are Health Maintenance Organizations, (HMOs). HMOs, however, come in various shapes and sizes. Some are staff model HMOs, in which the providers are employed by the HMO directly. Others, like Kaiser Permanente when it opened for business in North Carolina, are group model HMOs--the HMO contracts with a single group practice. Then there are Independent Practice Arrangements (IPAs) in which the HMO contracts with individual providers or members of groups. Blue Cross/Blue Shield's Personal Care Plan (PCP) is an example of this type of HMO. The newest HMO is the Point of Service Plan (POS). This can be used with any of the other types of plan--staff, group or IPA. In this model, a patient who uses the network provider pays less than a patient who goes out of the network. Point of service plans provide patients with more choice of providers, but may offer less cost control. Kaiser recently contracted with several independent IPAs and is therefore now considered to be a mixed-model HMO. Prudential's HMO is also mixed-model, using a combination of the IPA and group approach. An indemnity or fee-for-service insurance plan which adds utilization review or any other limits on access to providers can be defined as a managed care plan. Most HMOs in North Carolina follow the IPA model.

Our state has seen a dramatic increase in the number of HMOs and insurance based managed care networks. There are currently 22 full service HMOs licensed in North Carolina with an additional six applications pending. Eighty-five Preferred Provider Organizations are registered. Total enrollment as a percentage of total population under age 65 has grown from 6.2 percent in January 1992 to 11.8 percent in January 1995. Coverage in North Carolina is expected to move increasingly towards network-based managed care (PPO and HMO) in the near future.

Managed care is only one new market structure or process. Another market development is the integration of services and systems. Integrated delivery systems (IDS) are designed to improve health status, improve quality of life in the community, and provide health care services in an efficient, cost-effective manner. The four components of a fully developed IDS are: the enrolled patient; a vertically integrated provider network consisting of physicians, hospitals, and other providers that provide full continuum of care to the individual members of the system; a financing or insurance piece - moving towards capitation - and organizational components necessary to function, including clinical integration tools, information systems, and resource management services. IDS will rely more heavily on primary care physicians and non-physician providers as case managers or gatekeepers. Types of integrated delivery systems include

integrated service networks (ISNs) such as hospital affiliations or networks, physician hospital organizations (PHOs), and provider sponsored organizations (PSOs). All of these different types of delivery systems employ the common strategy of joining together in vertical or horizontal integration to provide health care, either contracting directly with employers or with HMOs and insurance companies.

The division between the provider and payer disappears or becomes less clear cut with the advent of managed care and integrated networks. Acknowledging the interdependence of workforce issues and delivery/payment systems, the Health Care Reform Commission sought to educate itself about the health care market trends in North Carolina. This section provides an overview of the information gathered about managed care markets in North Carolina and the creation of integrated networks. Workforce issues are covered in the section on access to health care.

I. COST CONTAINMENT

B. NORTH CAROLINA HEALTH MARKET TRENDS

1. REVIEW OF MANAGED CARE IN NC

At its March 27, 1996 meeting, the Commission heard presentations from a diverse group of individuals, all of whom have direct experience with the development and operation of managed care entities in North Carolina or nationally. The agenda was established to give the Commission members a broad overview of managed care in North Carolina from the perspectives of the regulatory agency, the industry management, a managed care physician, community hospital, large hospital networks, independent physicians, and consumers. Information was also presented about assessing quality in managed care and efforts to assist consumers in choosing a health plan.

NORTH CAROLINA DEPARTMENT OF INSURANCE

Definition of Managed Care

Ms. Barbara Morales Burke, Deputy Commissioner for Managed Care and Health Benefits, presented an overarching view of both the managed care industry, its implications for employers, individuals, and providers and the Department of Insurance's regulatory role with regards to managed care in North Carolina. The term "managed care" is used very broadly to describe companies (such as insurance companies and health care provider network companies), types of benefit plans, and sometimes even a philosophy regarding the delivery of health care services. The goal of managed care is to maximize the value delivered by a health plan. In this context, value includes lower costs

and quality medical outcomes accomplished through practices which emphasize primary and preventive care to promote wellness and efforts to deliver medical services in an "efficient" manner using services and providers that are "adequate" to treat the condition without being excessive.

Any benefits offered by managed care come at a price, either real or perceived. This cost includes some limits on choice of providers and required compliance with the rules and regulation of the plan, such as obtaining a referral for specialty care. For some people, these are small prices to pay and do not affect their medical care. For others, these limitations, especially restrictions on which physicians may be used, are not at all acceptable. Different interpretations of what constitutes "efficient" and "adequate" care and the possible inadequacy of some interpretations are other potential prices of managed care.

From a regulatory standpoint, the major difference between an HMO and a PPO or other indemnity insurance companies is the HMO's contractual obligation to those who purchase their coverage. HMOs promise to provide prepaid health care services either directly or via a network of contracted health care providers. PPOs and indemnity carriers promise to reimburse covered individuals for their covered medical expenses. This basic difference allows variations in provider compensation options available to each type of plan in their provider contracting arrangements. Only HMOs are authorized to sell prepaid health care, so only HMOs may contract with health care providers to deliver care on a prepaid basis. PPO and all other arrangements must be on a discounted fee-for-service basis where providers are not at risk for the amount of health services used by covered individuals.

An important distinguishing feature between HMO and PPO plans compared to traditional indemnity insurance plans is that PPOs and HMOs contract with certain selected health care providers and direct their plan members to them. The majority of HMOs and some PPOs use "gatekeepers," primary care physicians, who decide when use of specialty medical services is appropriate. In the case of traditional HMO plans, members have no ability to use providers outside of the plan network except in the case of emergencies. However, increasingly popular HMO point-of-service (POS) plans do offer some opportunity for members to use a non-network provider of their choice, in return for a lower level of coverage.

Benefit design also varies according to type of plan. Traditional indemnity coverage is limited to sick care, while managed care plans offer well care, with HMOs offering the most comprehensive well care. Benefit levels also vary between plan types. Indemnity plans make use of deductibles and coinsurance, while HMOs rely on fixed dollar copayments. PPOs make most use of deductibles and coinsurance, but have also begun to use copayments for some services.

Utilization management is another important distinguishing feature between types of health plans. This activity is at the heart of a plan's ability to promote "efficiency."

Although many traditional indemnity plans implemented basic utilization review features (such as pre-certification of hospitalization and prior approval for certain procedures) years ago, HMO plans make use of more comprehensive utilization management programs. These programs include:

- requirements to use a primary care physician who coordinates care by acting as a "gatekeeper" to specialty care;
- medical protocols designed to promote "efficient" and quality outcomes;
- use of case management to match the level of care to level of acuity throughout treatment (such as arranging for and covering home health care as a means of facilitating shorter hospital stays);
- prescription drug formularies; and
- preventative care and health promotion initiatives.

PPOs make use of utilization management programs, but their ability to do so is somewhat limited due to lesser use of and influence over contracted providers. Even within HMOs, gradations of utilization management exist, often due to the HMO model used.

Some Implications of Managed Care

Ms. Morales Burke identified the following as a partial list of potential implications of managed care:

Employers

For employers, possible implications include:

- Lower costs for health benefits and/or ability to provide more comprehensive benefits to their employees.
- Increased employee satisfaction (or dissatisfaction) with their health plan.

Individuals

For individuals, possible positive impact of managed care includes:

- Relatively predictable spending for health care costs - monthly premium (if any) plus low, fixed copayments when care is received.
- Coordinated health care orchestrated by a primary care provider.

- Potentially better health outcomes. Managed care plans cover preventive care and promote healthy lifestyles. Medical management and quality assurance programs of managed care plans should be designed to monitor outcomes and strive for increasingly better practice guidelines.

Possible negative impact of managed care for individuals includes:

- Restricted choice of health care providers and facilities. Sometimes managed care plan members still have wide choice, sometimes it is quite narrow.
- Potentially worse health outcomes, if a managed care plan sacrifices care for profits or if its medical management and quality assurance programs are deficient.
- Potential unexpected out-of-pocket costs if the treatment they need or desire is not deemed "appropriate" by their plan.

As the industry matures and employers and consumers have begun to demand evidence of the quality and value of managed care, managed care companies and other organizations, such as the National Committee for Quality Assurance (NCQA), have begun to develop "outcome measures." These are an attempt to measure the effect that managed care has on the health of its members. HEDIS, the Health Plan Employer Data and Information Set, developed by NCQA, is one example of such measures. These efforts are in varying stages of development.

Health Care Providers

Integration and Risk-sharing

Integration and risk-sharing are probably the major implication that managed care has for providers today. Some providers have employed adaptive strategies to achieve economies of scale, packaging their services along with those of other providers, gaining clout for a better bargaining position and becoming more cost effective by forming into large groups such as IPAs (Independent Practice Associations) or joining PHOs (Physician Hospital Organizations). All of these put them in a better position to work with managed care companies and to accept capitation or other risk-based payment for services.

HMOs in North Carolina are making increasing use of risk-sharing arrangements with providers. The most common form of provider risk-sharing is capitated payment. Under capitation a provider receives a fixed amount of money per month for each HMO member who selected that provider. The provider is then responsible for delivering all or most care needed and is paid the same amount regardless of the amount of care that is actually given. Large, integrated provider entities are best able to succeed under risk-

sharing arrangements, since they are able to "average out" expenses over a large number of patients and provide a broad range of coordinated services that are under their own control. It is important to note that this risk assumption is exactly what HMOs themselves have been doing since their inception.

Risk-sharing can present ethical and practical dilemmas for practitioners whose profession demands that they put the care and well-being of their patients first. The bottom-line incentive is to expend less resources in total. This can be achieved in two ways. The first is to simply provide less care. If the care that is no longer provided was unnecessary care, then this approach is a good one. However, cutting care beyond a certain point is obviously not acceptable. A second approach is to take a long-term perspective, relying on efficient practices and on preventative care and health screenings to catch health problems early.

Proponents of risk-sharing point out that it puts more control and flexibility regarding individual treatment decisions in the hands of the same medical professionals responsible for providing patient care and reduces the impulses of managed care plans to micro-manage them.

Though the provider is put at financial risk for delivery of services, the HMO is still the party held accountable to members to ensure the delivery of services promised by their certificate of coverage, and the HMO is still responsible for maintaining financial reserves adequate to pay for the provision of services to all of its enrollees. Some HMO risk-based provider contracts also tie components of compensation to performance measures such availability of appointments, patient satisfaction survey results, immunization rates and medical outcomes for selected conditions such as asthma and diabetes. These types of provisions are an important means of tempering the potential downside incentives of risk-sharing.

Managed care is having the effect of restructuring the health care delivery system. As the health care industry is shifted toward "big business," practitioners will have less independence and will be part of a larger corporate entity driven to some degree by financial incentives. Under this scenario, it is critical that provider-based entities strive to maintain a degree of independence for individual member providers, so that their traditional role as patient advocate is not seriously compromised.

Who Gets to Deliver Care & Services

The question of who gets to deliver care is also at issue. On one hand, because of the increasing penetration of managed care, participation in the networks of these plans becomes an issue of economic survival for providers. On the other hand, health plans need to obtain financially advantageous agreements with providers in order to deliver the lower-cost product that the market demands. Quality of care also needs to be a factor in provider selection and retention. The bases for provider selection and retention decisions are an area of growing tension between providers and managed care plans.

Representation (or exclusion) of different provider disciplines is also an issue arising out of managed care. Health plans must offer network providers capable of providing covered health care services, but often more than one type or level of provider is licensed or certified to provide such care. Demands by certain types of providers to be included in managed care networks are part of professional turf wars to some extent, but also touch on economic issues for providers and issues of choice for consumers.

Some claim that managed care plans' capitation of primary care physicians leads to underutilization of specialty medical care. This too touches on issues of provider economics, and on the quality of medical care. Increased focus on quality measures based on medical outcomes for managed care plans will help to examine this issue more closely in the future.

The markets for some types of health care providers have expanded as a result of managed care. The use of physician assistants, nurse practitioners, and allied health professionals has increased under managed care. As plans look for ways to closely match the health care needs of the patient to the lowest necessary level of intensity of care, various types of health care providers have expanded to fill the need. For example, many nursing homes have added sub-acute care and physical rehabilitation services. Opportunity for managed care plans to have members discharged from hospitals to these types of facilities represent savings for the plan and its members and increased revenue for these providers.

Societal and Public Health Implications

Number And Distribution Of Health Care Providers

Evidence appears to show that managed care can and does have an impact on the number and distribution of health care providers and health care facilities. It can exacerbate the long existing problems related to rural health care delivery systems. For example, hospitals with lower volume and offering a narrower range of services, often those in rural areas, are ill-equipped to compete with other hospitals for managed care contracts. Physicians are likely to fare better in urban areas than in rural, due to opportunities to be part of larger (perhaps multispecialty) practices with a better administrative capabilities, especially in a managed care environment. Community and public providers who have historically served the health care needs of otherwise underserved areas are at risk of being squeezed out of business as managed care plans move in, unless steps are taken to forge working relationships between these parties.

Cost Shifting

The phenomenon of cost shifting is impacted by managed care. In the past, cost shifting was used as mechanism to enable providers to make up for uncompensated and

undercompensated care rendered to individuals of limited means or with no health insurance by passing on higher costs to insured patients. As government programs tighten down on provider payment and managed care plans also press for lower costs, the ability of providers to care for the uninsured care is eroded. At the same time, employers demand that they not subsidize the cost of government programs. In some cases, limitations on coverage (either explicit or implicit) for certain treatments under commercial managed care coverage can have the effect of putting otherwise insured persons into the public system for care. Illness requiring long term treatment, such as some mental health disorders, are vulnerable to this occurrence.

Although cost shifting was not created by managed care, it is more acute because of it. Ms. Morales Burke stated that until some decisions are made regarding social obligations such as minimum coverage provisions and responsibility for the uninsured, this situation will persist and will likely worsen. She reported that the two most obvious choices are either to pay for such care through government funding or through the negotiated rates paid by managed care companies (which in turn will be passed on to employers and employees through higher premiums). Neither of these options is particularly popular.

Spending Decisions

Some people think of managed care as synonymous with the beginning of health care rationing. In reality, any spending decision regarding a finite sum of money is a form of rationing. As individuals, employers, and governmental entities, we all make decisions about rationing with respect to health care spending relative to all other expenditures.

Opting for a managed care health delivery system reflects health care spending decisions based on all of the principles that are the core of managed care:

- emphasis on wellness and preventive care with the expectation of improving health and reducing high-cost medical needs in the long term;
- emphasis on primary care for the purpose of coordination of care; and
- emphasis on reduction of "inefficient" and "inappropriate, unnecessary" care, for the purpose of cost savings and quality.

These principles are potentially beneficial for individuals and for society. However, some of these principles are potentially dangerous if taken beyond certain limits (especially if they are not flexible enough to vary from person to person, case to case).

Managed Care Activity in North Carolina

If any of the implications of managed care are important, the time to think about them is now according to Ms. Morales Burke, because managed care in North Carolina is

growing - both in terms of the number of managed care companies and the number of persons covered under managed care plans. Much of this growth has occurred between mid-1994 and now.

As of mid-1994, 10 full-service HMOs were licensed, all during the mid to late 1980s. As of today, there are 22 licensed full-service HMOs, and another 6 applications for licensure are under review by the Department of Insurance. HMO enrollment increased by 73% between December 31, 1992, and June 30, 1995, growing from 343,660 to 593,134. The number of PPOs registered with the Department of Insurance has grown from roughly 20 as of July 1993 to 85 as of February 29, 1996. PPO enrollment statistics are not currently available, but similar increases in enrollment would be expected in these plans. HMO enrollment in North Carolina is heavily concentrated in the urban parts of the state. The managed care presence in North Carolina is capsulated in the following chart.

MANAGED CARE PRESENCE IN NORTH CAROLINA

	July 1993 - June 1994	July 1994 - June 1995	June 1995 - Feb. 1996
Licensed HMOs*	10 FS, 2 SS	15 FS, 3 SS	22 FS, 4 SS
New HMO applications filed	5 FS, 2 SS	11 FS, 5 SS	4 FS, 3 SS
Registered PPOs	20 (est.)	62	85
Registered UROs	100 (est.)	128	144

◊ **Increase in managed care companies operating in North Carolina: 120% increase added in 19 months**

◊ **Persons covered under HMOs:**

12/31/92	343,660
12/31/93	397,608
12/31/94	516,648
06/30/95	593,134

73% increase

◊ **Geographic areas**:**

23% in Mecklenburg and 7 surrounding counties
35% in Wake and 7 surrounding counties
26% in Guilford and 8 surrounding counties
84%

*FS = full service; SS = single service

** Based on enrollment of insured HMO members (it does not include HMO self-funded business) as of June 30, 1995

Many people expect that the HMO market in this state will undergo a consolidation in the next one to three years. In other states where the HMO market is more mature, such as California and Minnesota, the same thing has occurred.

Some of the most important trends regarding managed care identified by Ms. Morales Burke are:

- Hybridization of products, dual and triple options
- Mixed model delivery systems

- Increased penetration due to gains in commercial market and new markets (such as Medicare, Medicaid and Workers' Compensation)

- Changes in structure and role of provider entities - larger, more integrated, joint ventures, stakeholders

- Evolution in provider compensation continues with broad-based capitation, performance-based incentives (service and medical outcomes, compliance) and increasing levels of subcontracting

- Continued growth, then consolidation

- Pressure on companies to deliver higher quality, contain costs

Department of Insurance's Regulation of Managed Care

Entities Subject to Department of Insurance Authority

The Department of Insurance has regulatory authority over HMOs and insurance companies, including those that sell PPO benefit plans. The Department does not have authority over the State Employees' Health Plan, Medicaid or Medicare, even when these programs make use of companies that the Department does regulate.

States do not have the authority to regulate self-funded single employer health plans (sometimes known as self-insured plans). Under this type of plan, an employer sets aside the expected amount of money needed to cover health claims of its employees and either processes the claims itself or, more frequently, contracts with an insurance company or third party administrator to administer claims. Self-funded plans of this type are regulated by the United States Department of Labor, under the authority of the Employee Retirement Income Security Act (ERISA). It is estimated that as many as half of all North Carolinians are covered under self-funded plans and have no protection by the Department for consumer or solvency-related problems.

The rule of thumb the Department uses to analyze PHOs, PSOs, IPAs and other such entities is to regulate based on actions and obligations, not on name. If an insurance product is sold, the Department regulates it; if insurance is not involved, the Department does not. Simple as this sounds, it is not always so simple in real-life application.

Scope of Department's Authority Over Regulated Entities

Traditionally, the Department of Insurance has looked for all health insurance plans to have financial stability, adequate reserves, fair rates, accurate advertising and to deliver on their promise to reimburse promptly for covered services. With a managed care plan, the Department needs to look at even more:

- When the plan has influence over which health care providers its members see, it should be responsible to make sure that these providers are competent and have legitimate and appropriate credentials. It should also take steps to make sure that the provider network includes enough doctors to serve its members and make sure that those doctors are accessible for timely appointments.
- When the plan uses medical management guidelines that can have an impact on what care a patient receives, it should make sure that it has a program to monitor how well those guidelines are working and how the patients' health is affected by their use. Standards for utilization management and oversight of company performance is critical. Utilization management is key to achieving the desired "efficiencies" of managed care, but also serves as the unspoken limits on coverage. In particular, acceptable determinations regarding emergency situations and medical appropriateness, as well as an ability to meet the medical needs of persons with long term and special needs must be assured.

The Department's regulatory activities relating to managed care include the areas of health care provider contracting, provider network adequacy, verification of health care provider credentials, benefit design and benefit policy language, utilization review programs, plan member services, quality assurance programs, claims payment, advertising and marketing practices, premium rating, underwriting and financial solvency. The brunt of regulation related to medical management and provider issues has been focused on HMOs to date, but managed care rules proposed by the Department will help to equalize requirements where company activities are comparable. All of the regulation is carried out by the Department through its licensure function, market conduct examinations, review of form provider contracts, review of policy, rate and financial filings, financial audits and handling of consumer complaints. See Appendix B for a summary of current and proposed regulations and a description of the roles of the Department sections involved with regulation of managed care entities.

Current Regulatory Limitations

Ms. Morales Burke stated that some of the biggest limitations that the Department faces in its regulation of managed care today are an outdated regulatory scheme, a lack of data and the capacity to collect and analyze data, and a narrowly defined ability to penalize companies. In general, NC's statutes and regulations do not address many relevant managed care issues and activities, which creates an unlevel playing field and other road blocks to regulation and enforcement. For example, HMOs and PPOs engage in many of the same activities, but current statutes fail to recognize this fact. The Department believes that it is important to maintain equality of treatment between insurers and provider-sponsored organizations. Again, when any entity acts like an insurer or HMO, they should be regulated in the same manner. However, it is also important that the Department maintain balance and not deliberately or inadvertently become regulators of health care.

Lack of good measures of performance is partially because the state of the industry is still evolving. Limitations in the Department's ability to collect and analyze data is due to manpower limitations, which unfortunately result in this important function taking a back seat to statutorily prescribed functions (such as market conduct examinations and licensure function) and to the lack of explicit authority regarding health plan report cards. Companies are comfortable with data collection in an examination setting, but are resistant to report card type comparisons.

Current HMO statutes allow the Commissioner to suspend or revoke an HMO license only for very specific and very serious violations of the law. The ability to issue cease and desist notices to HMOs and to fine health plans in lieu of suspension or revocation is tied to these same specific, very serious violations. In other cases, the Department has no option but to try to reasons with companies over an issue in an attempt to achieve cooperation. Even with the proposed managed care rules, changes to the law are needed in order to facilitate taking formal action against a company for certain managed care issues in a timely manner.

Additional Comments and Closing

In conclusion, Ms. Morales Burke expressed her opinion that any health care financing system is only as good as the adequacy of the funding behind it. If health care spending expectations are set unrealistically low, any scheme for providing health care coverage will be unsatisfactory in some regard. Assuming that financial reality precludes simply raising health care spending levels, the only answer seems to be to change the cost structure and incentives of the State's health care delivery system so that delivery is in sync with financing.

Managed care is that attempt to integrate health care financing and delivery. Currently it operates within a system that makes health insurance largely either a reward of those able to secure it through their employer or a helping hand to the poor. There is a growing number of persons caught in between these two groups, as employers seek to contain or even cut back their health benefit costs and funding for government assistance programs becomes scarce.

At any point in time, managed care is in some ways a mirror that reflects our ability and willingness, as employers, individuals and as a society, to pay for health care. Given appropriate regulation, such as minimum requirements regarding provider network adequacy and accessibility; quality improvement efforts; utilization management and requirements regarding minimum ratios of medical expenditures to premium, managed care plans can look as friendly or as frightening as desired. Of course, in order for such regulation to be effective, applicable requirements must be applied on a level basis to all types of managed care entities, including HMOs, PPOs and provider-sponsored organizations. The Department's proposed managed care rules will be an important step toward this end.

The health care delivery system in this country is in the midst of dramatic change. In many respects, the continued movement toward managed care seems to be a foregone conclusion. With appropriate forethought and oversight, this type of delivery system has the potential to yield more for the money on a system-wide basis.

THE INDUSTRY PERSPECTIVE

Robert Greczyn, Jr., addressed the Commission from his perspective as President and Chief Executive Officer of Healthsource, NC, North Carolina's largest HMO, covering about a quarter of a million people in North Carolina. When combined with the acquisition last year of a private insurance company, Healthsource is responsible for the health care coverage of about a half a million North Carolinians. He spoke in general terms about the managed care industry. Additionally, he provided details regarding the operation of Healthsource.

He acknowledged that the managed care industry is not perfect, but it is an industry which has much to celebrate especially considering its short history of a little more than a decade in North Carolina. In that short time it has gone from struggling to becoming a major way in which North Carolinians receive their health care. He described managed care as a form of health care coverage designed around the concepts of wellness and prevention based on the belief that when people receive care early and when disease is detected early, then costs are lower than in the traditional fee-for-service system.

HMOs encourage wellness and prevention. The industry has always covered well baby visits, immunizations, cancer screenings, mammograms, etc. as part of the basic philosophy of managed care. State laws mandating coverage of these services have never affected HMOs. The industry is now moving rapidly toward another concept in health care which is disease management, where a team works with physicians and patients to support their treatment efforts by providing other support services and tracking treatment regime compliance. Diabetes is a clear example of a disease for which there is no cure, but a disease for which patient education, management and supportive physician services can make all the difference. The majority of health problems are personal lifestyle-related and only with active patient involvement can society hope to truly improve the state's citizens' health status.

HMOs encourage patient/physician dialogue. For example, the Healthsource manual has an entire section on members rights and responsibilities. In this section members are told clearly that they have a right to understand and participate in their treatment decisions. Mr. Greczyn reported that Healthsource has never had gag rules, will never have gag rules, and will never get in the way of a physicians talking with their patients about anything they want to talk with them about.

HMOs are working together through the North Carolina HMO Association to make the industry even better. The industry has nearly completed developing a standard credentialing plan, and last year all the medical directors got together to begin a process of working with prominent local obstetricians and gynecologists to develop standard guidelines for certain procedures. Local physicians establish guidelines for care.

Regarding the industry's responsiveness to consumer questions and appeals, he offered the following data. First, North Carolina's HMOs have stellar member satisfaction. These figures are generally above 90 percent and for Healthsource that number is above 93 percent. Additionally, and by way of example, Healthsource last year showed an increase of 13 percent in membership gains in existing groups, in addition to a four to six percent overall growth rate in 1995. That 13 percent figure is particularly impressive because it is achieved primarily by word of mouth. Contracts contain detailed descriptions of the health plans' appeals process which must be approved by the Department of Insurance. Healthsource tracks appeals carefully and responds thoroughly. Appeals are settled in the consumer's favor about 80 percent of the time. Most are settled at the first appeal level based on additional information. Today emergency room visits are rarely denied. Of those emergency room visits that are denied, over 90 percent are overturned on the first level of appeal. The appeals process is clearly responsive to consumer's needs.

Addressing the issue of quality, Mr. Greczyn stated that the old fee-for-service system did virtually nothing to assure quality. HMOs have advanced the issues of quality in many very significant ways. HMOs credential physicians based on stringent guidelines supported by National Committee for Quality Assurance (NCQA); basically all HMOs are seeking NCQA accreditation or have already received it. As a part of that process, Healthsource reviews physicians training, licensure, and also visits their office. Equipment is checked to make sure that it works. Charts are reviewed to ensure that record keeping is accurate and complete.

Healthsource also does random practice specific satisfaction surveys of its members on a routine basis. Members who have visited their physician's offices are asked about their satisfaction with their waiting time as well as with the care they have received. Any quality issues identified through these processes are referred to a quality improvement committee of local participating physicians. Physicians' practice patterns are profiled quarterly. Using the Johns Hopkins Ambulatory Care Review system those profiles are illness-adjusted to eliminate the issue of the physician saying, " but my patients are sicker." Healthsource is able to compare apples to apples and to provide this information to its physicians.

Healthsource conducts numerous studies. For example, Healthsource just completed a study of breast cancer looking at the time it takes from the diagnosis of breast cancer to the initiation of treatment. Many HMOs work in the area of certain types of disease conditions like asthma and diabetes. In both of those areas, Healthsource is working very hard to develop disease management approaches as well as to change

coverages to better reflect today's treatment regimens. Immunization and mammogram rates are tracked on a regular basis. Healthsource reviews, of the nine recommended immunizations, how many kids in the plan have had all nine by the time they are two years old. The Healthsource rate is 93 percent, much better than the overall community. Regarding mammograms, about 75 percent of women over 50 have had a mammogram. Women over age 50 who've had their mammogram are sent a birthday card every year asking them to get their annual mammogram if they haven't done so, compliance and follow-up through their physicians is tracked.

Healthsource continues to look at ways to identify higher risk obstetrics patients early in their pregnancy. Some obstetricians don't have the time or the resources to do some of the early intervention processes that Healthsource can get involved with. Further follow-up is conducted to ensure that members are complying with their obstetricians' treatment requirements and that they get any other support services needed to try to have a better outcome for their pregnancy.

Data from the office reviews, practice profiles and other studies are provided to Healthsource doctors, not in a punitive way, but in a way that allows them to gain knowledge. Over the last couple of years, scores for office reviews have gone up dramatically, because physicians take that information and make changes in their offices. This overall change in the focus of medicine is described as evidence-based medicine. That is medicine based on evidence that the treatment method works and is cost-effective, rather than being based on what has always been done.

In health care delivery, primary care physicians are taking their place as the patient's guide to the health care system, ending what Mr. Greczyn calls "medicine by wandering around." The primary care doctor can provide the vast majority of care and will refer to specialists to treat particular problems. Primary care physicians are not complaining about managed care. Specialists, on the other hand, who are facing a less certain future are complaining more about managed care.

In short, North Carolina HMOs are providing quality, affordable care to about a million North Carolinians. Medical policies are set by local physicians and the industry continues to work hard improving itself and supporting quality care. Mr. Greczyn stated that now is not the time to reverse course. Health care costs are moderating and managed care satisfaction and growth are strong. To reverse this trend would be in his opinion bad public policy, and it would lead to the reinitiation of spiraling costs. He states that North Carolina will never even begin to solve access to care problems without addressing the underlying cost problems.

THE MANAGED CARE PHYSICIAN PERSPECTIVE

Dr. Robert Bilbro, a managed care physician with Healthsource, spoke from his experience in practice in Raleigh for 23 years where he has worked as a primary care

physician and as a consulting cardiologist. He has been involved with managed care for about ten years with a group of physicians in the Triangle who felt that if they tried to resist the movement they would be run over. Several of the group's members felt the best way to have an influence was to work with the system and try to influence the evolution that seemed inevitable. Thus, he has been involved with managed care since 1985 from a planning process, and, for ten years, a portion of his patients have been under managed care. He emphasized five points which are summarized below.

First, the core value of patient care is still there. What is changing is the delivery system in the formation of networks and in the economics of the system for the doctor or the nurse whether it be in the examining room, the emergency department, the operating room, the laboratory or the bedside. The core values of patient care have changed only to become more effective in that there is more that can be done that makes a difference in health outcomes. Evidence-based practice, which is more and more an emphasis within the specialty societies across the United States and Canada, is an effort that is scientifically driven that improves quality and fits in nicely with what managed care is trying to do not only to be more cost effective but to enhance quality as well.

Second, managed care was not just dreamed up by a creative group of thinkers, but it is a necessity. Managed care takes many different shapes and forms and is constantly changing, constantly evolving, but that it came into being in response to society's needs. The United States had evolved a system of care delivery which had really gotten out of control. The increase in technological capabilities has had a logarithmic progression. Economic incentives unfortunately pushed some elements of the provider system to use more of this technical capability than is perhaps necessary. Further, the third party payer system, wherein the consumer or the patient uses all this technological capability and sends the bill to the insurance company, sends it to Raleigh, or sends it to Washington, created a problem and a lack of economic accountability within the system. The threat of legal suits has driven the system also.

Third, Dr. Bilbro paraphrased Dr. Eugene Stead who said that what the patient needs is a doctor to coordinate services, and managed care works to systematize and meet that need. In the past, a patient would be seen by one group of specialists for one medical problem and then another would treat another organ system and so forth and there was a real tendency for the patient to be lost in that fragmented attention despite receiving highly technical, highly skilled care. There has been criticism of managed care calling the primary care physician "gatekeepers" in a negative connotation, but they might also be called gate openers, or gate coordinators or system orchestrators. There is a clinical need for a patient to have someone who is responsible for all aspects of the care, trying to coordinate that care to help that patient get through the sometimes confusing maze of services available.

Fourth, the health delivery system is in the midst of a transition and there will not always be as much turmoil. Currently, the transition is causing a lot of turmoil for the practicing physicians and young people who are coming out of medical schools and

training programs. There are clear indicators that the market is changing. With the shift to the use of more primary care physicians There will be a need more of those and there will be a need for less of the proceduralist. And this is disruptive and threatening and disturbing to the proceduralist. Dr. Bilbro cited as an example the possible role of an ear, nose and throat (ENT) doctor. In Raleigh, the Triangle or any community, as more and more of the population is under managed care, fewer ENT doctors per thousand population will be needed, but what will evolve is that the ENT doctors will spend more of their time doing cancer surgery and less of their time seeing runny noses, which is really a better use of their time. It will be more economically rewarding for ENT doctors eventually, but the rate of growth in their practice will be much slower. In fact it's even arrested in some situations.

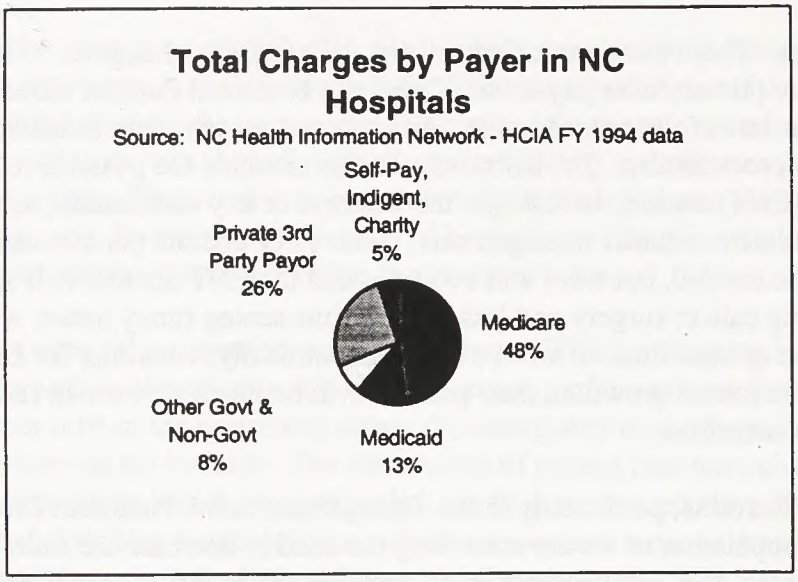
In North Carolina, particularly in the Triangle and in the Piedmont Crescent, we have a growing population so we are not seeing the need to decrease the cadre of specialists in a given area, but they just aren't growing as rapidly. There is turmoil during the transition time, and once we've evolved further along through the transition there will be less disturbance among physicians.

Fifth, thoughtful physicians must recognize that under any system there is a need and a challenge to balance economics and professionalism. Dr. Bilbro states that we can't afford unbridled capitalism. The system cannot be purely for profit, that would not serve us well. Nether can we allow a system where the physician just focuses on his or her individual patient and tries to seek maximum care for his patient without consideration of the economics of the situation. There will always be that struggle to balance professionalism and whatever delivery or financing system is in place, whether it is a fee-for-service, or managed care or a capitated system. Dr. Bilbro identifies patient care as a priority for the profession and that the profession needs to adapt that priority to the reality of the networking and the economic reimbursement system that are the means to the end.

Dr. Bilbro closed by restating the core value of patient care and his confidence that as the profession hangs on to that focus it can adapt and work within whatever system evolves. Further he is hopeful that physicians will continue to have an effective voice in the relevant evolution of that system.

COMMUNITY HOSPITAL PERSPECTIVE

Robert Morrison, President of Randolph Hospital and member of the North Carolina Health Care Reform Commission, opened by saying, "There is a great deal of uncertainty about how managed care will develop in North Carolina; and this Commission is squarely in the middle of the uncertainty. Still, there are some conclusions which we can reach and there are actions we can take to assure the best possible outcome." After briefly reviewing managed care and some of its tenets, Mr. Morrison proceeded to provide the Commission his viewpoint of managed care as a manager in a community hospital in a county with both suburban and rural characteristics. He stated that he was sharing his personal perspective.



The above pie chart shows where hospitals send their bills. Medicare and Medicaid are now on "per case" reimbursement in most hospitals. Most of the "charge payers" are in the private third party payer segment. It is no coincidence that this is the segment most rapidly moving into managed care.

North Carolina is still early in the transition to managed care, and it varies a lot from market to market. When Medicare and Medicaid are on DRG payment systems and much of the other reimbursement in managed care contracts, hospital prices no longer matter. For every dollar of price increase, a hospital may receive 10-cents to 30-cents. A West Coast colleague reported several years ago that for every dollar that his hospital raised prices, he could collect four-and-a-half cents. That is one result of the change from indemnity insurance to managed care contracts. Managed care contracts most frequently pay on a per diem or per case basis. Hospitals are at financial risk for overuse of resources without much opportunity for up-side gain from declining utilization.

Hospitals have experienced declining utilization and that trend is expected to continue. In 1994, there was 56 percent occupancy of licensed hospital beds in North Carolina. If that utilization declines to the average national HMO rate, it will be around 39 percent. The very most aggressive HMO's have pushed hospital utilization so low that 20 percent occupancy is now theoretically possible. Looking at utilization, hospital days per thousand population declining from 823 per thousand in 1990 to 690 per thousand in 1994. The goal is to improve quality and reduce costs. Reducing hospital utilization and payments may be a way to that goal, but not if it creates even more cost elsewhere in the system.

With revenue per patient day going down and patient volumes going down, then one would expect that health care costs should be going down. The answer seems to be "maybe" or "yes but". As hospital inpatient volumes go down, outpatient, home care, and

other volumes rise, and the administrative costs associated with managed care rise. As a result, it is not yet clear that total health expenditures are going down.

Much has been made of the cost shift over the past few years. Everybody who showed up at a community hospital got service, regardless of ability to pay. If Medicare or Medicaid didn't pay enough or if the patient could not pay the charge, hospitals just raised prices to the insured population, the 26 percent on the above table, and made up the difference. Some called it an invisible tax.

Those were the old days. The cost shift is nearly gone, whether it was right or wrong. Managed care firms negotiate very aggressively for the best prices from hospitals and doctors and are willing to exclude a provider if the price is not right. The only scientific study of this subject that Mr. Morrison had been able to locate studied the effect of market changes, similar to those NC is experiencing now, in California hospitals in the late 1980's. The demonstrated result was a 36 percent reduction in charity care as a percentage of the total care provided at not-for-profit community hospitals. Probably there is no one in California who wanted that outcome, but it happened. Mr. Morrison believes it will occur here also.

As the cost shift disappears, as charges to managed care firms go down, resources to care for the uninsured shrink proportionally. Last year, Los Angeles County and a university closed a major inner-city hospital and its clinics. The losses could no longer be absorbed and there was no place to shift the cost. Details about the impact on the community and on the nearest community hospitals when the uninsured population fills their emergency departments have not been published. In Asheboro, North Carolina, with unemployment below 4 percent, 25 percent of the emergency room visits are uninsured patients. The potential load in an inner-city during a recession is much greater.

Mr. Morrison offered the following three rules for a successful transition to managed care in North Carolina:

- Managed care will help to reduce cost and improve quality if its positive attributes are developed. Focus should be on the positive attributes.

- Managed care appears to be the future of the market and of health care. It's okay to lead or to follow, but don't get in the way.

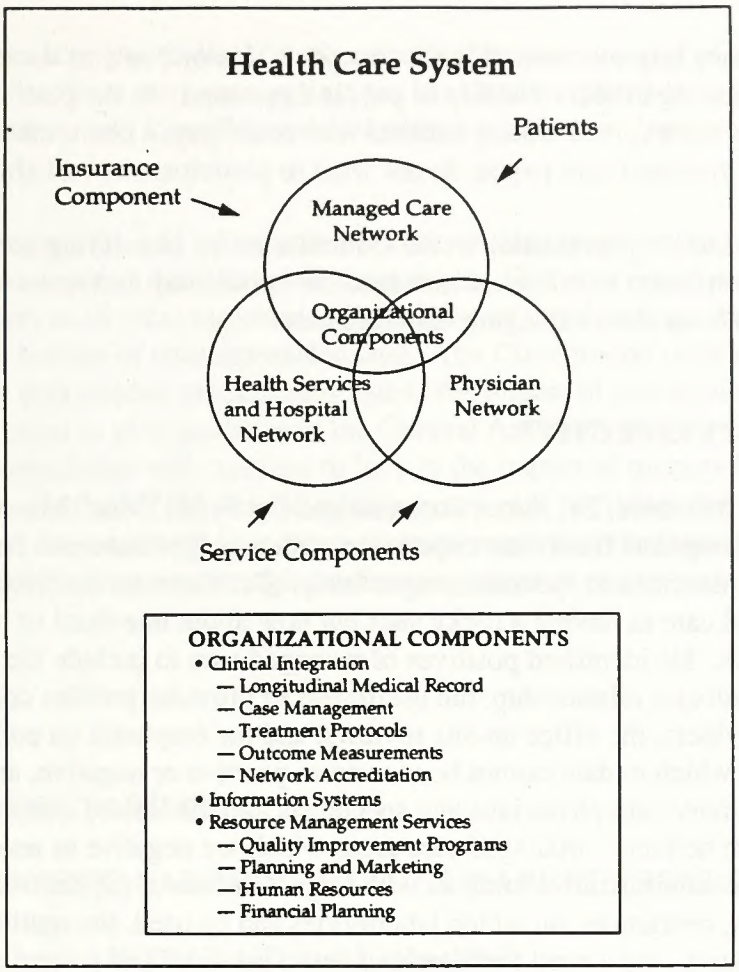
- If managed care is the future, quit whining about how great the old days were! Society couldn't afford them. Let's make the most of the future by creating the right managed care environment in North Carolina.

He concluded that while managed care probably should be regulated, it should not be thwarted. Mr. Morrison posed some very specific recommendations to the Commission which may be considered at a future meeting.

THE LARGE HOSPITAL NETWORK PERSPECTIVE

Mr. Gregory J. Beier, executive vice president with Carolina Medicorp, Inc., addressed the Commission from his perspective as a manager in a large integrated health care services and hospital network. Mr. Beier opened by identifying the dilemma that needs to be faced: the United States has developed a health care system that has excellent capability to deliver care to the sick and injured; however, it is no longer affordable and it is not improving the health of our communities proportionate to the resources being consumed. From the perspective of a large hospital network, managed care can be the best approach for solving this dilemma. He offered the following definition of managed care: The alignment of the components of the health care system through redesigned patient management and care delivery programs, to optimize use of resources to enable improved quality of care at a lower price. All elements of the system, industry/payer, physician, and hospital must participate in managing care and develop methods to lower costs and improve outcomes.

Mr. Beier reviewed the Carolina Medicorp's organizational structure which includes a managed care network with an HMO branch and a PHO branch, a physicians support network consisting of 18 practice groups, and the health services and hospitals network which includes four hospitals, eleven outpatient centers, two rehabilitation centers, a women's center, three wellness and preventive care centers, two residential continuing care facilities and a home care agency. He identified the positive aspects of managed care for a large health care system with multiple intersecting components as represented as in the figure below.



Instead of operating as individual components, the entities have been encouraged to operate as a system. To manage care appropriately, the organization has expanded its continuum and developed an infrastructure aimed at improving the health of the people in the region, not just caring for the sick. Primary care physicians have a key role in managing care and have been integrated into the system. Physicians are involved with governance, management and development of methods to improve systems of care resulting in quality improvement and cost reduction. One area of focus is clinical improvement which includes developing clinical pathways, guidelines/protocols and Clinical Improvement teams.

From the large health care system perspective, managed care has presented some negative aspects. Many traditional payer methods have "managed price" and not "managed care" demanding extraordinary discounts on unit price which does not change the underlying cost structure. The use of methods to micro-manage physicians and lower utilization also does not change the underlying cost structure and jeopardizes quality. An unwillingness or inability to share information necessary for the physicians and hospitals in the system to make fundamental change has been observed. Many payers do not seem interested in making fundamental change to alter the basic cost structure and achieve

substantial performance improvement. Finally, hospitals' historic role as the care provider to all citizens, regardless of ability to pay, is threatened. In the past uncompensated costs were spread among patients who could pay, a phenomenon called cost shifting. Many managed care payers do not want to participate in cost shifting.

Mr. Beier closed his presentation to the Commission by identifying some opportunities for government to influence managed care positively and some issues that should be avoided to keep from damaging managed care.

THE PHYSICIAN PERSPECTIVE

Commission members, Dr. James Forrester and Dr. F. M. "Mac" Mauney, provided personal viewpoints from their experience with managed care as a family practitioner and a cardiothoracic specialist respectively. Dr. Forrester described his history with managed care as having a rocky start but now about one-third of his patients are in HMOs or PPOs. He identified positives of managed care to include the strengthened patient/doctor relationship, the usefulness of provider profiles comparing his practice to other providers, the office on-site reviews, and the emphasis on complete records. Two areas, which to date cannot be viewed as positive or negative, are reduced incomes for both primary care physicians and specialists and the loss of control in the process of health care delivery. Managed care areas which are negative or need improvement include administrative burdens with large volumes of paperwork and the pre-approval process, restrictions on which laboratories can be used, the multitude of credentialing procedures, and a need for more and better provider and patient education. Dr. Forrester also highlighted that under managed care providers cannot continue to provide charity care because there are very limited opportunities to cost shift.

Dr. Mauney reviewed the growth of managed care and the role of the physician. He closed his presentation by requesting that three principles be keep in mind as managed care grows. First, physicians either need to be in charge or be general partners in shaping managed care systems. Second, patients cherish the right to choose their provider. Finally, the system must preserve and support the doctor/ patient covenant.

The Commission heard testimony from two consumers, one who was disappointed in the care she received for a second, high-risk pregnancy under a managed care plan and one who expressed confidence and satisfaction with the care she and her family had received under managed care.

Steve Lamb with the National Committee for Quality Assurance addressed the Commission on his organization's activities in assessing and reporting on the quality of managed care plans. An overview of his presentation is included as Appendix C. To acquaint the Commission with emerging technology which makes use of computer software to assist a consumer in selecting a health plan which may or may not be a managed care plan, Jeff Johnston demonstrated a software package his company is

developing. Interacting with displays the consumer answers a series of questions, the software evaluates those responses against the health plan options from which the consumer may chose and identifies and ranks those plans which best meet the consumers needs.

The Commission had a productive session on managed care and will certainly return to address some of these issues in more depth. One area which was identified by several presenters as of great importance is the issue of the shrinking ability of providers to cost shift the burden of uncompensated care. The Commission indicated that it will begin to collect data needed to accurately assess the impact of managed care growth on charity care in order to give guidance to the General Assembly and the Governor. In addition, the commission will continue to look at the impact of managed care on the adequacy of the number of physicians, other primary care providers and facilities in rural and underserved areas and will investigate ways to encourage the market to ensure access, quality and cost effectiveness through good management of patient care.

I. COST CONTAINMENT

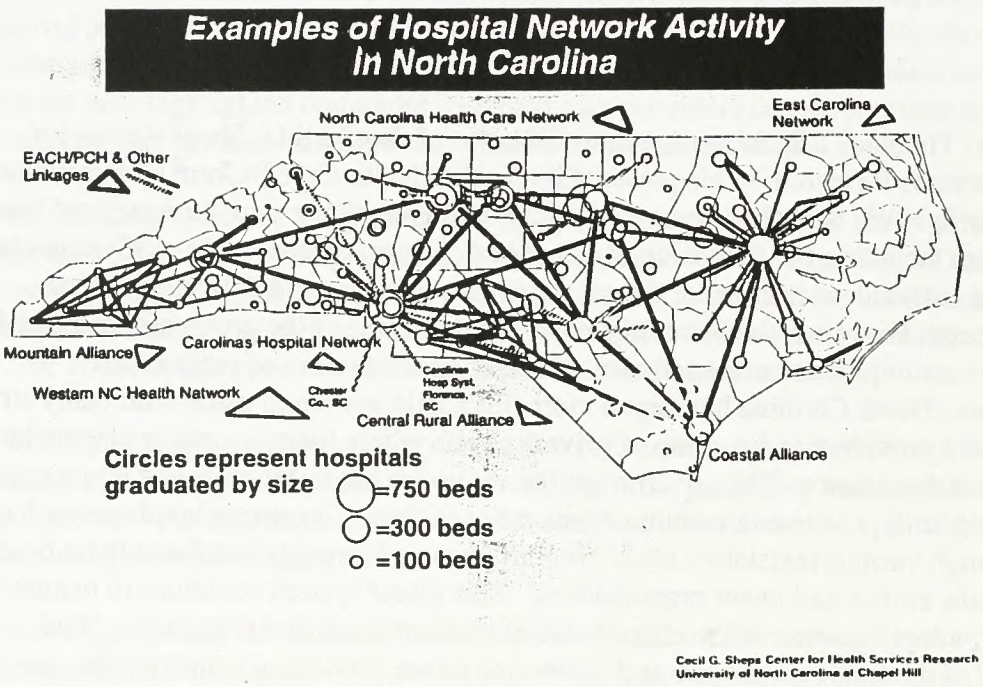
B. NORTH CAROLINA HEALTH MARKET TRENDS

2. INTEGRATED NETWORKS

Dr. Thomas C. Ricketts, Assistant Director of the Cecil G. Sheps Center for Health Services Research, in his presentation to the Health Care Reform Commission on November 8, 1996, described some of the market driven changes to the American health care system including the formation of integrated delivery systems. North Carolina has not been a market leader in either the managed care or integrated delivery systems development. However, the State may have avoided some of the problems associated with rapid assumption of managed care and rapid concentration of services and institutions. North Carolina has kept a more pluralistic system in place with many strong, independent providers and a group of private payers where there are major players but no exceptional dominance. The government has moved to create systems and structures in partnership with private and community-based providers. Consumer involvement has been through various legislative study commissions and through membership on boards of hospitals, clinics and payer organizations. This plural system continues to mature in its own way, adopting some of the efficiencies of managed care and integration. The character of the State, its peoples and professionals are producing a market structure that cannot be clearly classified according to the definitions proposed by others.

In 1994, there were 120 acute care, general hospitals which provided 4,379,135 days of care in 21,596 licensed beds. This excludes beds for research, substance abuse, psychiatry, rehabilitation, hospice and long-term care. The occupancy rate for these licensed beds decreased from 60.7% in 1991 to 54.6% in 1994. This drop in occupancy is considered to be a result of pressures put on the system by the Medicare prospective payment system and the spread of managed care. Nationally there has been a slight upswing in the total number of admissions (up 2.8%) while staffing in hospitals has declined. The market for hospital and hospital services in North Carolina is regulated by a licensing process and, for most types of hospitals, a certificate of need (CON) is required of construction or replacement. The CON process regulates the expansion of acute care beds and specified services offered in hospitals. Teaching and research facilities are exempt from certain parts of the CON process. New hospitals have been built in the Charlotte area in the recent past, but overall demand has declined across the State. There is a substantial over-supply of hospital beds in North Carolina.

There is a national trend toward merger or affiliation of hospitals into larger networks or systems. North Carolina has a growing number of networks with linkages that range from very loose associations, to management contracts to shared ownership. There are, however, no statewide chains or networks of jointly owned hospitals although there are multiple hospitals managed by companies such as Quorum or Sunhealth on a contract basis. Most linkages and mergers in North Carolina are taking place at the local and regional level. Examples of these networks are provided in the following map.



Every part of the State is included in some form of alliance or network structure. The linkages are usually in the form of a hub and spoke alliance system such as the ones

involving the Carolinas Medical Center and the Pitt County Memorial Hospital. Other networks are structured without a central large hospital(s), the Central Carolinas Rural Health Alliance is an example of this arrangement.

The linking of larger to smaller hospitals has occurred in several places across the State. Three Rural Hospital Alliances were set up with the help of the Office of Rural Health and Resource Development under the federal Essential Access Community Hospital-Rural Primary Care Hospital (EACH-RPCH) program initiative. Other urban-rural links include the Montgomery County Hospital structured agreement with Moore Regional Medical Center and the UNC Hospitals system link with Chatham Hospital. Other larger regional referral centers have working agreements and contracts with most of the smaller hospitals in the State. Two Asheville hospitals, Memorial Mission and St. Joseph's, are the only applicants for the State-sanctioned Certificate of Public Advantage which theoretically immunizes participants from anti-trust sanctions for joint activities. Ten hospitals have formed a statewide alliance, the NC Health Care Network, that would allow them to bid for contracts with firms and government agencies which employ people throughout NC.

Several reasons have led to the formation of these network structures including the need to create "right-sized" organizations which can offer managed care options across larger populations. A pressing financial impetus is the need to maintain or increase market shares. Smaller hospitals need to link with larger hospitals to assure access to tertiary services and professional support.

There are moves to form linkages between insurance companies and hospital networks. These include partnerships between Duke and Sanus (Metropolitan Life), UNC Hospitals and Kaiser and Healthsource, Partners and Forsyth Hospital (Carolina Medicorp) and Presbyterian Hospital and Kaiser. The most developed alliance is the alliance between Duke Hospital and its physician network and Sanus in conjunction with the Wellpath HMO.

There are also what might be called cooperative-competitive arrangements. North Carolina Baptist and Forsyth, for example, collaborate over obstetrical services; UNC and Duke are discussing shared pediatric responsibilities; and Pitt County and Craven Regional cooperate in cardiovascular treatment. The Memorial Mission and St. Joseph's partnership is intended to reallocate services and resources that were previously competed for between the hospitals.

North Carolina has slightly fewer beds per thousand than the national average (3.4 versus 3.5 in 1992) and approximately the same hospitalization rate as the nation (126.5/1000 versus 125.3/1000 in 1992) but a significantly longer average length of stay, 7 days versus 6.3 for the nation. Hospitals in the state are working to reduce the average length of stay to control costs. In one urban community, for example, an examination of patterns of care and hospitalization found that longer lengths of stay were due to the lack of capacity in local home health and long-term care facilities, the admission of patients for

problems that could be taken care of in less acute facilities and a perception that referrals to other agencies might not be handled effectively. Both the findings and the perception of cross-institution problems push organizations to consider vertical integration of services. In fact, several of the larger hospitals in the State have begun to link together long-term care, rehabilitation, urgent care, and ambulatory care in systems that move the patient more efficiently from one level to another.

It is reported that the networks of services is the easy part of partnering, the more difficult part is the alignment and integration of the financing systems across institutions and organizations. This is due to the nature of health care delivery where individual providers cared for individual patients and each separate organization created its own accounting system that dealt with costs, expenditures and incomes in different ways. Financial structures often influenced the structure of clinical data systems. Thus, it is difficult to align an acute care delivery system which accounted for costs on a procedure and itemized input basis with a chronic care system that used days as the measure of costs. Structural alignment problems happen as organizations with different cultures combine in partnerships and the clinical philosophies must be coordinated as well as the financial and structural.

Hospital-led physician organizations are developing, Charlotte offers two examples with the Carolina Medical Center and Presbyterian physician networks very active in the Metrolina region. The Duke network represents a developed teaching hospital physician organization; UNC, ECU and Bowman-Gray have also developed physician organizations focused on the teaching hospital. These groups also have affiliated primary care physician networks.

Across the State, large and small physician organizations are developing in most major cities. The Cardinal Group in Raleigh is an example. In High Point, Cornerstone Health Care with 50 physicians, sixty-five percent of whom are in primary care, has been created. Statewide physician groups based in particular specialties are also being established; for example, a family practice group associated with the North Carolina Academy of Family Practice has been set up. These more formal arrangements operate within the context of established referral and professional relationships which have grown up over the years. For example, the Area Health Education Centers Program (AHECs) distributed residency programs and special agreements for cancer and cardiovascular care have created strong links between physicians in groups and on staffs of hospitals. These arrangements may differ within a community by specialty with a group of physicians allied with specialists in one city for one type of care and another group in a different city for a different specialty.

While public health units are not often seen as a part of the general health care delivery market, local departments and other publicly supported clinical and service organizations provide a substantial amount of care to North Carolinians. These clinics and delivery organizations are now entering into partnerships and joining with private and other community-based systems of care. The partnership between the Charlotte-

Mecklenburg Hospital Authority and the Mecklenburg County Health Department is one example of joint activity. In Cleveland County the health department and hospital are jointly developing a clinic and coordinating services and the Warren County Health Department and the Vance-Warren Community Health Services share a building and have merged their services.

North Carolina is a fairly unique health care market in the United States. It is characterized by a large number of independent and strong regional providers, a diverse payer group, a health professions education system that provides a steady stream of professionals and services to the State, and a public sector that has been very active in making health care services available to poor and rural residents of the State. These patterns of pluralism and independence are relative to the rest of the nation where concentration and centralization among providers and payers has been more the norm. Still, the State has begun to create regional systems that reflect the integration elsewhere. In one sense, the provider and payer systems are adjusting to be equally competitive.

North Carolina's steady economic and population growth will allow it to absorb the growth of new competitive forms, but this will happen only in those areas where growth is occurring. In North Carolina the problem of rural areas, where growth is stalled or economies have not been able to replace a declining agricultural base with new jobs and income increases, remains for developing managed care and integrated delivery systems.

I. COST CONTAINMENT

C. SMALL BUSINESS INSURANCE

1. SMALL EMPLOYER BUSINESS MARKET -- DOI

Small businesses are the largest creator of new jobs in North Carolina. Historically, they have also been the most likely place of employment for those who are employed and uninsured. Efforts to assist small businesses find affordable insurance for their employees have been underway since January 1, 1992. At that point legislation went into effect requiring the North Carolina Department of Insurance working with the insurance industry to develop affordable health insurance options for small businesses in the state.

The following statistics and more detailed information in Appendix D are an updated report of the results of those efforts;

A. <u>3 TO 25 MARKET</u>: (Original Definition of a Small Employer, in affect from January 1, 1992 until December 31, 1993)

- 6,793 groups were issued a small employer group health benefit plan..

- 2,108 (31%) were employer groups which were previously uninsured.
- Based upon the average number of employees covered (7.2), 15,178 employees in employer groups without insurance for at least 30 days obtained health insurance during 1995.
- 6,385 (94%) groups were issued a traditional plan.
- 408 (6%) groups were issued a statutory plan.

- Top Five Carriers who accounted for 46% of the plans issued:
  Blue Cross Blue Shield of North Carolina.
  John Alden Life Insurance Company
  Principal Mutual Life Insurance Company
  Travelers Insurance Company
  PHP, Inc.

  These five carriers issued 67% of the plans in 1994. In 1995, these carriers and 5 others combine for 67% of the plans issued. The other carriers are Trustmark Insurance Company (Mutual), New England Mutual Insurance Company, Fortis Benefits Insurance Company, Employers Health Insurance Company and TMG Life Insurance Company.

- 198,342 employees in 27,639 groups were covered as of December 31, 1995.

- 3,748 employees in 662 groups were covered with a statutory plan.

- Top Ten Carriers who accounted for 76% of the policies in force as of 12/31/95:

Blue Cross Blue Shield of North Carolina	7,464
Principal Mutual Life Insurance Company	4,349
John Alden Life Insurance Company	3,702
Travelers Insurance Company	1,641
PHP, Inc.	731
Employers Health Insurance Company	702
Mid-South Insurance Company	675
TMG Life Insurance Company	584
Fortis Benefits Insurance Company	559
Kaiser Foundation Health Plans of NC	558

- Net change in number of plans issued from 1992 to 1995 was 933.

- Average number of employees based upon all plans was 7.2.

B. <u>ONE-MAN/SELF-EMPLOYED MARKET</u>: (Part B of the survey element requested information regarding self-employed individuals as defined in NCGS 58-50-110(21a). However, due to the inability of some carriers to capture this specific data, this section includes one-man groups. These one-man groups may, or may not, meet the definition of a self-employed individual).

- 6,986 individuals were issued a small employer group health benefit plan.
  - 2,135 (31%) were employer groups which were previously uninsured for at least 30 days during 1995.
  - 6,322 (90%) individuals were issued a traditional plan.
  - 664 (10%) individuals were issued a statutory plan.
- Top Five Carriers who accounted for 78% of the plans issued:
  PFL Life Insurance Company
  United Wisconsin Life Insurance Company
  Blue Cross Blue Shield of North Carolina
  Principal Mutual Life Insurance Company
  Trustmark Insurance Company (Mutual).
- 15,242 individuals were covered as of December 31, 1995.
- 774 individuals were covered with statutory plan coverage.
- Top Five Carriers who accounted for 77% of the policies in force as of 12/31/95:

PFL Life Insurance Company	7,937
Blue Cross Blue Shield of North Carolina	1,334
United Wisconsin Life Insurance Company	1,159
Prudential Insurance Company of America	874
Principal Mutual Life Insurance Company	432

C. <u>1 TO 49 MARKET</u>: (Definition of Small Employer in effect as of January 1, 1995. This data includes the data in Part A and Part B)

- 20,481 groups were issued a small employer group health benefit plan.
  - 6,001 (29%) were employer groups which were previously uninsured.
  - Based upon the average number of employees covered (5.6), 33,606 employees in employer groups without insurance for at least 30 days obtained health insurance during 1995.

- 19,117 (93%) groups were issued a traditional plan.
- 1,364 (7%) groups were issued a statutory plan.

- Top Five Carriers who accounted for 53% of the plans issued:

PFL Life Insurance Company	3,251
Blue Cross Blue Shield of North Carolina	2,060
TMG Life Insurance Company	2,616
Travelers Insurance Company	1,628
Principal Mutual Life Insurance Company	1,216

- 298,705 employees in 53,819 groups were covered as of December 31, 1995.
- 6,015 employees in 1,843 groups were covered with statutory plan coverage.
- Top Ten Carriers who accounted for 73% of the policies in force as of 12/31/95:

Blue Cross Blue Shield of North Carolina	10,749
PFL Life Insurance Company	8,213
John Alden Life Insurance Company	5,808
Principal Mutual Life Insurance Company	5,770
Travelers Insurance Company	2,422
United Wisconsin Life Insurance Company	1,628
PHP, Inc.	1,174
Trustmark Insurance Company (Mutual)	1,147
Employers Health Insurance Company	1,146
Mid-South Insurance Company	1,130

- Average number of employees based upon all plans was 5.6.

NOTE: The Department of Insurance developed this summary based upon data provided by insurance companies participating in the small group health insurance market in North Carolina. Because some insurance companies approximated the data, the data may not accurately reflect the actual market.

I. COST CONTAINMENT

C. SMALL BUSINESS INSURANCE

2. STATE HEALTH PLAN PURCHASING ALLIANCE

The purpose and intent of the Alliance program is to increase the affordability, efficiency and fairness of health care coverage for small employers. In 1993, the General

Assembly created the State Health Planning Purchasing Alliance Board (State Board) to promote the development of voluntary purchasing alliances. The mission of the Alliances is to provide more affordable health care coverage for self-employed individuals and employees of participating small businesses in a manner similar to large employer groups. Alliances will allow members to benefit from the contracting expertise and the administrative savings that can result from pooled purchasing.

Effective as of April 1, 1996, the Health Alliances covered 89 groups with 272 total covered lives including employees and their dependents. Of those, 20 groups consisting of 57 lives were previously uninsured; the other 80 percent had some previous coverage.

Alliances will make available a choice of insurance carriers, called Accountable Health Carriers, that would be responsible for arranging quality health services in a cost-effective manner. The State Board was required to develop rules for fair competition among these Accountable Health Carriers, including the offering of comparable benefits plans from each Accountable Health Carrier and the development of a risk assessment and adjuster to ensure that risk is being spread evenly across all participating carriers. The State Board is also responsible for analyzing data on clinical outcomes, customer satisfaction and other measures of performance from Accountable Health Carriers and regional Alliances.

The eleven-member State Board was appointed during the late fall of 1993. An executive director began work in January 1994, and two additional staff positions were added by May. A fourth person was added to the staff in February, 1995.

Following several months of educational forums, business groups led primarily by Chambers of Commerce expressed interest in becoming community sponsors for regional Alliances. The first such group, the Asheville Chamber of Commerce, supported by over 20 chambers in Western North Carolina, submitted a proposal in June of 1994, which was accepted by the State Board in August.

The Pitt/Greenville Chamber of Commerce, in partnership with other chambers throughout Eastern North Carolina, submitted a proposal in November 1994, which the Board approved in December.

Following these proposals, the Board approved applications from the Fayetteville Chamber of Commerce for 11 counties in Southeastern North Carolina and from Union County Chamber of Commerce for nine counties in South-Central North Carolina in February, 1995. The Board recently approved applications from the Durham Business and Professional Chain for the Triangle area and from the Wilkes Chamber of Commerce, in conjunction with the chambers in Watauga, Alleghany, Ashe and Caldwell counties, for counties in Northwest North Carolina and the Triad area.

All six regions are now incorporated and in operation as private, non-profit organizations. These corporations will serve as the governing structure and marketing units for the Alliance program.

In May, 1995, the State Board negotiated a contract with HealthPlan Services, Inc., a third-party administrator on behalf of the Alliances to provide "back-office" support for each regional Alliance, including billing, marketing and other functions related to the support of the program.

Beginning in the early summer of 1995, the regional Alliances, the State Board and its staff and various interest groups have been participating in a series of work sessions to determine administrative procedures and rules, guidelines for sales, marketing and general alliance operation. A request for bids from Accountable Health Carriers was issued in August of this year, with bids returning in mid-October.

The Alliances, now operating under the name "Caroliance," have opened their doors for testing. Beginning mid-1996, an aggressive marketing campaign will begin.

There are approximately 148,750 employers in the state with fewer than 49 employees. Over one million people in North Carolina are employed by small businesses. Including their dependents, the total market of small employees is over 1.8 million lives.

See APPENDIX E for more information.

I. COST CONTAINMENT

D. PUBLIC PURCHASING

The General Statute creating the N.C. Health Care Reform Commission lists a number of things that the Commission "shall do" and on which it "shall report." One of these items is to "increase the health purchasing power of government." Two meetings have been held by an ad hoc task force comprised of representatives of the NC County Commissioners Association, the NC League of Municipalities, the State Employees Association, the NC Association of Educators, the State Employees and State Teachers Health Plan, the State Budget Office, the NC Division of Medical Assistance, the NC Hospital Association and others to begin the examination of how state and local governments in North Carolina purchase health care services. The concept with which this task force is examining the issue is how or whether to move governments into active participation in a market driven approach to "smart" purchasing in order to save tax dollars. Under this concept, government would look at itself as a distinct purchaser participating in the competitive marketplace.

For several years the NC League of Municipalities has offered a health insurance pool for many cities and towns. The largest cities in the state, have opted for a self-funded

arrangement. Within the last year the NC Association of County Commissioners has elected to begin a health insurance pool for its counties; some 65 have already signed up. The largest counties in the state have also opted for a self-funded arrangement. Both the League of Municipalities and the Association of County Commissioners have seen costs of providing health care coverage for employees increase as well as other health related costs increase. For the State of North Carolina, the State Budget Office estimates that one-third of the state's budget is spent for health care -- through health insurance for employees and teachers (700,000 covered individuals), Medicaid (1 million individuals), provision of hospital coverage through NC Memorial and the state institutions, etc.

The ad hoc task force is examining the outcomes of such practices as wellness benefits and if, over the long-term, these can add value and save tax dollars. All-payer systems, pooled purchasing for health care supplies, simplified purchasing, benefits comparisons, etc. are all areas which this group may study. These studies will assist the Commission in meeting its mandate to "increase the purchasing power of government health programs" as proscribed in the "shall do" category of the legislation.

At the time of this report it is not clear if these studies will lead to specific recommendations by the Commission. It may well be that the state already enjoys cost efficiencies not realized in other markets. Conversely, studies may reveal that more collaborative purchasing of health care by state and local governments could save the taxpayers substantial amounts of money.

II. UNINSURED/COVERAGE

A. UNINSURED

The tables that follow show the number of uninsured North Carolinians dropped by 8.8 percent between 1994 and 1995. There were decreases in every age category except adults 18-49 and for each income category except those below 100 percent of the federal poverty level. This indicates a 13.3 percent level of uninsured for the state of North Carolina.

North Carolina Uninsured Population estimated from US 1994-95 Census CPS March Insurance Supplement

Age Group	1995 white	1995nonwhite	1995tot	1994 white	1994 nonwhit	1994 tot	Change 1994-95
<1	4913	6621	11534	7475	2458	9933	1601
1-5	28232	23333	51565	30793	42969	73762	-22197
8-17	82826	44334	127160	114092	85552	199644	-72484
18-29	184504	102574	287078	193682	80851	274533	12545
30-49	206925	104231	311156	202574	101025	303599	7557
50-64	89214	30353	119567	101450	31739	133189	-13622
65+	6157	3739	9896	10188	2048	12236	-2340
			917956			1006896	-88940
Poverty Class							
<100% FPL	145078	134950	280028	171462	88422	259884	20144
100-124%	38786	28544	67330	57081	39770	96851	-29521
125-199%	139660	48580	188240	139985	102402	242387	-54147
200-399%	185251	83049	268300	191638	91304	282942	-14642
400%+	93997	20060	114057	100088	24743	124831	-10774
			917955			1006895	-88940

The number of uninsured North Carolinians dropped by 8.8 percent between 1994 and 1995.
There were decreases in every age category except adults, 18-49
and for each income category except those below 100% of the federal poverty level

Although the drop from 13.8 percent registered in March of 1991 is good news, the numbers need to be looked at with caution. Duke health policy professor Dr. Christopher Conover points out that the "general rule of thumb is to use a 95 percent confidence interval for deciding whether a change over time is significant." This requires the difference between the new rate and the old rate to be roughly two times the standard error of the difference between the rates. Using this criterion, the apparent upward jump in the uninsured rate to 14.7 percent in March 1992 was not a statistically significant change since 1.1 percentage points is much less than the 2 X 1.0=2 percentage points needed to constitute a significant change. A 90 percent confidence requires the changes to have exceeded 1.65 times the standard error of the difference, so even using this more liberal criterion, we cannot conclude that 1992 was different from 1991.

The state's uninsured rate in 1994 was 14.9 percent with a standard error of 0.6. In this case, decline to 13.3 percent is not significant at the 95 percent level but is significant at the 90 percent level. The problem is that the sampling of uninsured poor went up implying that none of the observed change could be attributed to Medicaid expansions (presumably, without Medicaid, the numbers would have gone up even more). Thus, the apparent reason for the "decline" in the uninsured relates more to coverage principally among the near poor. Figures from the EBRI and Urban Institute show this comes from more employer-based coverage. It's possible this happened, but it's more likely that the new and improved Current Population Survey sampling method found people with employer-based coverage who previously were counted as uninsured. It makes sense that this kind of improvement in reporting would occur disproportionately among those with less education and lower incomes. Thus, it is likely that much if not all of the apparent decline in coverage is attributable to the new survey method rather than a genuine trend. The fact that the number of uninsured poor rose in the face of a known expansion in Medicaid is disturbing (but again, not much can be made of this fact given the small numbers) At best, it appears that there has been no change in the number of uninsured poor. SEE APPENDIX F for more information

II. UNINSURED/COVERAGE

B. MEDICAID

The North Carolina Health Care Reform Commission is required to monitor any changes taking place in Medicaid, but specific oversight of the program itself has been given to the Blue Ribbon Task Force on Medicaid. House Bill 230, Section 23.5A establishes in the General Assembly a Blue Ribbon Task Force on the issue of the potential impact of federal block grant funding and other federal actions on Medicaid in North Carolina. The Task Force is to report within one week of the opening of the 1996 Regular Session unless a Special Session is called to address federal block grant funding issues. The North Carolina Health Care Reform Commission is working cooperatively with the Blue Ribbon Task Force on Medicaid issues.

During State Fiscal Year 1995 there were 1,068,939 Medicaid recipients in North Carolina. The average expenditure per recipient for that year was $3,321. Care was provided by a total of 38,015 Medicaid providers* including 23,929 physicians, 3,098 dentists, 2,345 pharmacists, 1,026 optometrists, 801 chiropractors, 361 podiatrists, 261 ambulance companies, 160 home health agencies (including physical, speech and occupational therapies and home infusion therapy sessions), 138 durable medical equipment suppliers, 309 intermediate care facilities for the mentally retarded, 194 hospitals, 151 mental health clinics, 417 nursing facilities, one optical supply company (a single source purchase contract), 342 personal care agencies, 96 rural health clinics, 19 nurse midwives, 64 hospices, 351 CAP providers, 58 other clinics and 3,894 other providers. The total expenditures by the Medicaid program in SFY 1995 were $3.6 billion. Of this amount $2.2 billion was federal, $942 million was state appropriated, $198 million was state transfers, and $187.9 million was county funded.

Congress created the Medicaid program in 1965. It was designed to be a medical safety net for two major categories of low income people receiving cash assistance: (1) mothers and children and (2) elderly, blind and disabled persons. Medicaid is jointly financed by the federal and state governments. In North Carolina, the 100 counties contribute to the non-federal share of costs. All states, the District of Columbia and some territories have Medicaid programs. Medicaid programs are governed by federal guidelines, but vary in eligibility criteria and covered services. In North Carolina, counties determine eligibility for Medicaid.

North Carolina began participating in the Medicaid program in 1970. At that point, it was administered by the Division of Social Services. A separate Division of Medical Assistance was created within the Department of Human Resources in 1978. From 1978 to 1995, Medicaid expenditures and eligibles grew from $307 million to $3.6

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* The count of physicians reflects each provider number assigned to an individual physician or a group practice of physicians. Most physicians practicing in a group practice have an individual provider number in addition to the group number. Also physicians who practice in multiple settings are included once for each practice setting.

billion and from 456,000 to 1,138,786 respectively. The staff of the Division of Medical Assistance totals 282. County and state administrative costs together equal 3.5 percent of the total program dollars.

Medicaid is available for certain categories of people specified by law, based on financial (income and resources) criteria. North Carolina's Medicaid program has two main components, a categorically needy program and a medically needy program.

The categorically needy group consists of people who receive or are eligible to receive cash assistance payments under other assistance programs or who are specially authorized by law. These include:

- recipients of Aid to Families with Dependent Children (AFDC) payments, foster care and adoption assistance(Title IV-E) payments, SSI (Supplemental Security Income) payments, state/county Special Assistance payments, or supplemental assistance programs to visually handicapped individuals

- pregnant women

- infants and children up to age 19

- persons age 65 and above or persons who are blind or disabled (as defined by the federal Social Security Administration criteria) who qualify for Medicare Part A and have income and assets below federal standards.

For the aged, blind and disabled federal regulations permit states either to accept as categorically needy all persons found eligible for federal Supplemental Security Income (SSI) program or to set categorically needy eligibility criteria that are more restrictive than SSI standards. Until January 1, 1995 North Carolina elected the latter approach, making it one of 13 "209(b)" states, so-named for the statutory citation explaining this option. What this meant is that SSI recipients had to make a separate application to North Carolina's Medicaid program and meet more stringent financial means tests to become eligible for coverage. Beginning January 1, 1995, North Carolina SSI recipients automatically qualify for Medicaid benefits.

The medically needy meet the same general requirements as the categorically needy but do not receive cash assistance payments, generally because their income is higher than state standards allow. If the medically needy individual's income is higher than the allowable level, he or she must spend the excess income on medical care before becoming eligible. This is known as the Medicaid deductible or "spenddown."

Medicaid is a central source of health care for North Carolina's most vulnerable citizens: aged, blind and disabled individuals, pregnant women, and low income families who cannot afford to pay their own health care expenses. The state fiscal year extends from July 1 to June 30. In SFY 1995, Medicaid spent almost $3.6 billion for health care

services for 1,138,736 North Carolinians. For 1995, this represents just over 16 percent of North Carolina's population. In SFY 1995, Medicaid was able to serve 7.5 percent more needy recipients than in the year before.

As in past years, the largest proportion (67.1 percent) of Medicaid's service budget was spent for services to aged, blind and disabled individuals. The remainder, 32.9 percent was spent on care for low income families and children. About 28.7 percent of the service budget was spent on nursing facility care and on institutional care for the mentally retarded. The remainder was spent on other types of preventive and acute care services for other eligible groups and for program administration.

As Congressional leaders and the President tackled the serious issue of controlling the federal deficit and balancing the budget, Medicare and Medicaid became the most controversial topics in the discussions that have taken place. These programs were targeted because they consume such a large proportion of the federal budget and because the historical rates of expenditure growth far exceeded increases in revenues. But the debate went well beyond issues of budgets, and divergent philosophical opinions overtook the funding debate. The philosophical difference primarily involved whether Medicaid should remain a federal entitlement program with federal guidelines and oversight, or whether a block grant of federal funds should be given to the states and where all coverage decisions would be made.

Changes to Medicaid are still under debate as of this report and are expected to continue throughout the election year, but nevertheless, the attention devoted to the program made all states including North Carolina consider how Medicaid must change if it is to remain a health care safety net available for our most vulnerable citizens.

One strategy often proposed was to use managed care as a more cost efficient way to deliver quality care. Some states elected to move virtually their entire Medicaid populations into capitated managed care plans. Arizona never operated a traditional fee for service Medicaid program. In 1982, under a Section 1115 waiver, Arizona implemented a statewide Medicaid managed care system which benefits from health plans, private and public, competing to provide health care to Medicaid beneficiaries in both urban and rural areas. Initially, Arizona had a waiver exempting it from providing the full scope of Medicaid services. However, it now offers the full range of services having added family planning, behavioral health and long-term care over the years. Arizona is the only state that mandates enrollment in managed care and capitates the cost of all care. Tennessee's TennCare is a statewide demonstration project designed to provide health care benefits to Medicaid beneficiaries, uninsured state residents and those whose medical conditions make them uninsurable. Through twelve Community Health Agencies, all enrollees are served in capitated managed care plans for all services except long-term care.

Other states chose less extensive strategies, but most of them have moved some of their Medicaid population into managed care. Most of those affected have been AFDC women and children a healthier and thus lower cost group of recipients. For example in

North Carolina, the elderly comprise 16.5 percent of the eligibles and use 33.9 percent of the dollars; the disabled make up 10.9 percent of the eligibles and use 33 percent of the payments; and families and children comprise 72.6 percent of the eligibles but use only 33.1 percent of the service dollars. The elderly and disabled generally tend to be more expensive because on the whole they have greater medical needs and have greater use of long term care services. The average cost per enrollee in the fiscal year 1995 was $1,322 for families and children, $5,922 for the elderly, and $8,658 for the disabled. States are beginning to explore how managed care can be used with elderly and disabled populations.

North Carolina's movement into managed care can best be described as cautious. Three specific strategies have been pursued:

- a primary care case management model called Carolina ACCESS,
- a prepaid plan for behavioral health called Carolina Alternatives,
- an emphasis on contracting with licensed HMO's.

As is true of all health care funding programs, the system is fragile and interdependent. When there are major changes in Medicaid laws or the employment picture in North Carolina, there are corresponding changes in the numbers of citizens who are uninsured. Accordingly, when unemployment rates soar, Medicaid eligibles and uninsured persons increase, when the economic picture improves, the numbers of eligible and the numbers of uninsured go down. All aspects of the picture must be watched together for all public policy makers to have a clear picture of the needs of the state.

SEE APPENDIX G for more information

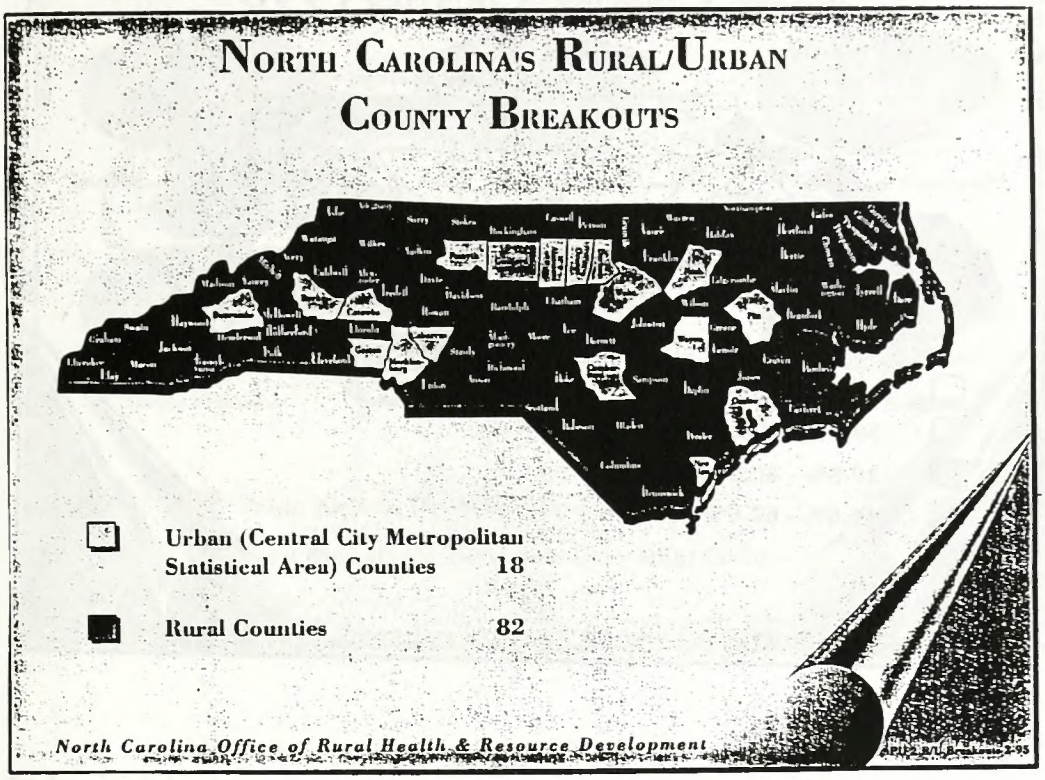
III. ACCESS

A. RURAL ISSUES

1. ACCESS TO HEALTH CARE IN RURAL NORTH CAROLINA

Since the early 1970s, the North Carolina General Assembly has made significant investments in its rural health care infrastructure and has developed the nation's most extensive system of rural health programs. However, despite these investments, the state still experiences difficulties in attracting and retaining primary care physicians and other providers to rural communities and maintaining sound rural health systems. This section will outline the existing resources and problems of rural health and recommend needed solutions to address many of the long-standing issues surrounding rural health care in North Carolina. For the purposes of this section, "rural" is considered one of the 82 counties in North Carolina without a urbanized/central city greater than 50,000. The 18

counties considered "urban" are Alamance, Buncombe, Burke, Cabarrus, Catawba, Cumberland, Durham, Forsyth, Gaston, Guilford, Mecklenburg, Nash, New Hanover, Onslow, Orange, Pitt, Wake, and Wayne. (Please see map.)

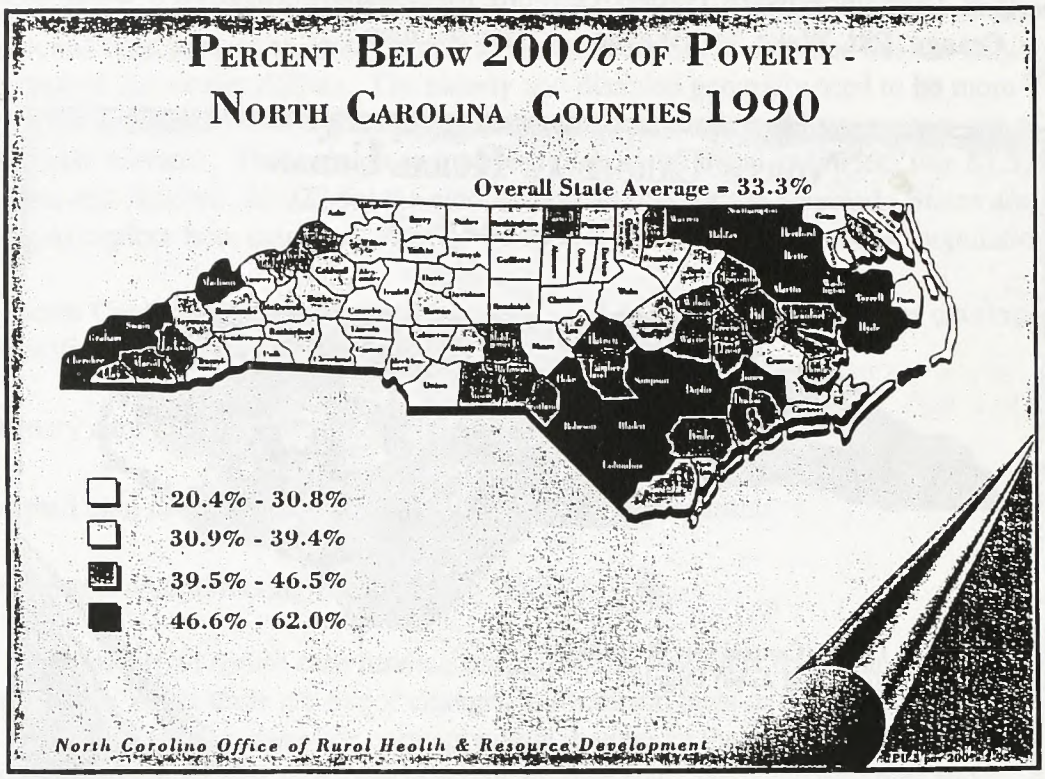


The Problems of Rural Health

Residents of rural North Carolina suffer from higher rates of poverty and have access to fewer primary care physicians and health care professionals than urban residents of the state. About 16.5 percent of rural residents live in poverty, compared with about 11 percent in urban North Carolina, and these high poverty rates can mean low insurance coverage for rural residents.

In 1990, one-third of North Carolinians lived below 200 percent of poverty, which then was $25,400 for a family of four ($30,300 in 1995). These percentages are much higher in rural counties of our state, particularly in the northeast, the southeast and mountains.[1] (Please see map.)

[1] N.C. Office of Rural Health, data analysis, 1995.



Poor rural communities have difficulty recruiting primary care physicians and other providers, in large part because of their remoteness and the personal demands on providers and their families. While rural North Carolina has experienced an increase in health care providers since 1970, 34 counties have a significant shortage of primary care physicians and another 30 counties have either a township or special population with limited access to primary care physician services.[2] This typically means that there is the equivalent of only one full-time physician for every 3,500 or more people in the county or township.

The problem is not necessarily the overall supply of primary care physicians, which has steadily grown since the 1960s, but rather the distribution of these physicians and their services. The same can be said for the supply and distribution of physician assistants, nurse practitioners, and certified nurse-midwives, advanced practitioners who provide important primary health care services. Overall, almost half (48 percent) of the state's 1992 population lived in a rural county, that is a county without a city whose population is greater than 50,000. However, only 31 percent of primary care physicians lived in those 82 rural counties. (Please see diagram.)[3]

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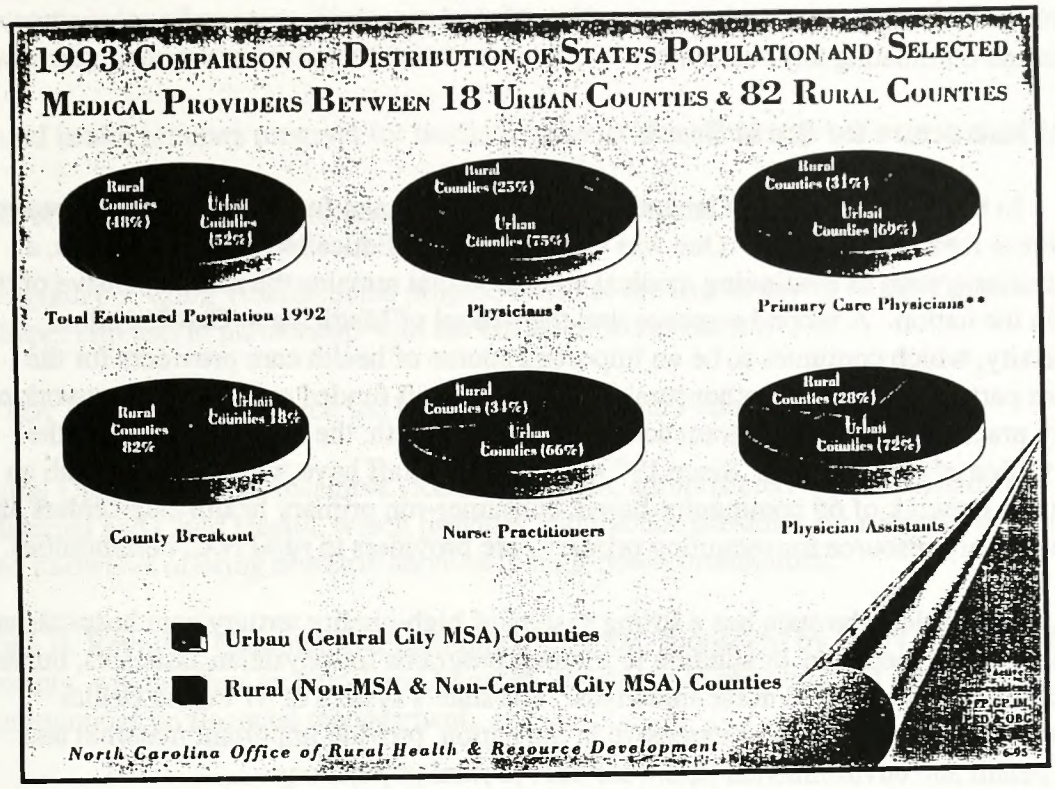
[2] *Ibid.*
[3] *Ibid.*



Community hospitals in rural communities also are undergoing difficulties in recruiting primary care physicians. Changes in medical technology and the subsequent increase in outpatient procedures caused a significant decrease in hospital occupancy rates. For example, under aggressive managed care organizations in California, hospital days for the population younger than 65 years of age is less than half the rate for that same population in North Carolina.[4]

As noted above, the current consolidating forces in the health care industry threaten to destabilize already fragile rural primary health care systems. Managed care has proven to be successful as a means of serving more residents at lower costs. However, managed care organizations tend to be based in urban areas, and many rural practices are unprepared to negotiate or collaborate with these larger organizations.

Finally, labor markets are weaker in rural areas, which means that many rural workers are uninsured or underinsured. Many rural workers have a low level of skills, and thus are often in jobs with a fewer benefits than urban workers. In comparison, the urban job market is so competitive that employers are forced to offer high-quality health insurance in order to attract labor. The traditional method of paying for uninsured people,

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[4] Presentation by Jim Bernstein, Health Care Reform Commission, December 14, 1995.

in both rural and urban health systems, has been to shift those costs to other third party payers. Increasingly, both private and public third-party payers are targeting their own clients and eliminating any cost shift.

An Infrastructure for Rural Health

In the early 1970s, the General Assembly created and funded four key components to address rural health issues. One was the Area Health Education Center Program, a nine-center system of continuing medical education that remains the most extensive of its kind in the nation. A second resource was the School of Medicine at East Carolina University, which continues to be an important source of health care providers for the eastern part of the state and other rural areas. Thirdly, it funded an extensive network of family practice residency program across the state. Fourth, the legislature created the N.C. Office of Rural Health. Since 1973, the Office's staff have worked to establish an extensive network of 65 community-based, consumer-run primary health care centers and is the primary resource for recruiting primary care providers to rural N.C. communities.

In addition, the state has a strong system of high-quality tertiary care hospitals and four schools of medicine, in addition to training programs for physician assistants, nurse practitioners, and certified nurse-midwives. The state's system of 87 Public Health Departments, among the most extensive in the nation, provide important maternal and child health and environmental health services to rural populations.

Many state agencies—using state, federal and/or grant dollars—support rural health programs. Some examples of these programs:[5]

- Extensive and continuous technical assistance to community-based, consumer-operated health centers;
- Limited capital and operational grants to selected community-based health centers;
- State and federal loan repayment for physicians and other providers locating to targeted rural and medically underserved urban practices;
- High-need service bonus payments to physicians and other providers locating to targeted rural and medically underserved urban practices;
- Medical placement services for physicians and other providers interested in locating to rural and medically underserved urban practices;

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[5] Adapted from "Rural Health: An Evolving System of Accessible Services," Tracey M. Orloff and Barbara Tymann, National Governors' Association, Health Policy Studies Division, Center for Policy Research, 1995, pp. 209-216.

- Residency stipends to primary care medical residents and physician assistants, nurse practitioners and nurse-midwives in training who agree to locate in targeted rural and medically underserved urban practices;
- Rural health scholars program for medical students interested in practicing in rural NC;
- REACH-TV, a telemedicine model based at East Carolina University;
- Program on Aging Telemedicine project, based at the University of North Carolina at Chapel Hill and in partnership with the Office of Rural Health;
- NTIA Telemedicine Project, led by the Office of State Planning;
- Rural Obstetrical Care Incentive (ROCI) program, administered by the Division of Maternal and Child Health, which provides malpractice subsidies for rural physicians and midwives offering obstetric services in high-need communities;
- Kate B. Reynolds Community Practitioner Program, sponsored by the N.C. Medical Society, which offers technical and financial assistance to physicians in rural communities on financial management;
- Locum tenens services for selected rural physicians; and
- Continuing medical education and rural-based training through the state's extensive AHEC system.

III. ACCESS

A. RURAL ISSUES

2. THE *LOCUM TENENS* PROGRAM

During the 1995 Session of the General Assembly, Chapter 507 of House Bill 230 allocated $100,000 to the Office of Rural Health and Resource Development in July 1995 to start the *locum tenens* project and charged the North Carolina Health Care Reform Commission to "(a)ssess the impact of the *locum tenens* program". The Office of Rural Health entered into an agreement with the East Carolina University School of Medicine to provide *locum tenens* services to high-risk counties in the eastern part of the state that lacked sufficient manpower. The Commission has not yet studied this issue. However, a brief background and review of the status of the project through March 1996 are detailed below. The complete report to the NC Health Care Reform Commission on *locum tenens* will be presented at a future meeting.

Background

There are multiple reasons for the physician shortage in rural areas. Many rural doctors earn lower salaries than those physicians providing the same services in cities. For example, starting family physician salaries in urban HMOs can reach $135,000, but some rural centers can only afford to offer the same physician about $80,000. Many younger physicians who have families often are discouraged from practicing for lower salaries.

In a recent study by Sari Teplin for the North Carolina Rural Health Research Program at the Sheps Center for Health Services Research, insufficient time off and excessive demands on time were cited as top concerns of physicians leaving rural practice. Rural physicians often work in jobs with exceptional levels of on-call hours. Another recent study by the Sheps Center found that in 26 rural counties, 20 percent or more primary care physicians reported that they were on call for 73 or more hours each week.

Rural physicians providing care in a solo practice or in small groups also have problems with "burnout," because coverage is difficult to obtain and call schedules are demanding. When solo doctors choose to take leave, they often are forced to close down their practices and suffer a financial loss for the time that their practices are closed. Other causes of the physician shortages include the fact that many rural areas often offer limited employment opportunities for the spouses of physicians, and poor educational and recreational opportunities for their families.

Rural physicians often postpone or fail to pursue continuing medical education or to take a vacation because of many factors, including 1) their practices lose revenue when they are gone; 2) they must continue to pay their staff when they are gone; 3) they want to offer continuous medical service to their patients; and 4) the cost of finding another physician through a private sector agency to cover for patient care is prohibitively expensive. Practitioners in rural and underserved areas who are not able to pursue continuing educational opportunities often miss out on seminars and courses vital to keeping up with the uses of the latest in medical technology.

The culmination of these factors is a high burnout rate for doctors practicing in rural and underserved areas. The turnover rate in these areas was extremely high, and many doctors left their practice and moved to a different area of the state where they could practice medicine with a higher salary, have more educational opportunities, have the opportunity to take time off, have a scheduled family vacation, and generally have better living situations for their families.

Locum tenens services are when a physician substitutes temporarily for another. While these practices are available privately, their costs are often far beyond what a rural practice can afford. Thus developing a subsidized *locum tenens* program that provides affordable service to providers in rural and medically underserved areas can prove a useful tool for state policy makers wishing to strengthen care in targeted medically underserved rural communities.

Typically a *locum tenens* doctor spends a period of time at a practice filling in for a physician who is away due to illness, vacation, or educational opportunities. The income generated by the covering physician would remain in the practice, and the covered doctor would be responsible for the costs of the covering physician's lodging and travel expenses.

In a *locum tenens* program connected to an academic program, a *locum tenens* could be the new faculty member for his/her base institution and could be required to teach and see other patients. He/she would receive all the benefits of a faculty member as well and would be paid through the parent institution. Other models could have *locum tenens* assignments rotated among a group of faculty physicians. In addition, still other models could utilize residents—graduated medical students who are fulfilling medical residency training requirements—to substitute for vacationing physicians in need of *locum tenens* support.

Implementation

The Office of Rural Health and Resource Development targets its *locum tenens* services to community practices in medically underserved eastern counties that struggle to maintain their staffs to serve local residents, many of whom are poor and have few other options. Currently 12 weeks of *locum tenens* coverage have been contracted for underserved communities through East Carolina University. The *locum tenens* physicians offer 40-plus hours of service per week.

The Office of Rural Health's *locum tenens* project has continued the goals of a Medical Society Foundation's project in that the doctors serve underserved areas and the structure allows physicians the opportunity for personal time. The Office of Rural Health program also targets the same types of underserved practices that the pilot project did, serving the eastern counties that need the *locum tenens* services the most.

Feedback from rural practitioners, faculty and health centers has been overwhelmingly positive toward the Office of Rural Health's efforts. Currently, the Office is making plans to expand and strengthen the program to serve medically underserved communities and their physicians statewide.

In the future, according to Burnie Patterson, assistant director, the Office of Rural Health will expand the *locum tenens* project beyond the eastern part of the state. One key obstacle to achieving this goal is finding an appropriate number of practitioners to provide reliable and high quality *locum tenens* services. "It is difficult for one individual to maintain a year-long schedule of providing *locum tenens* services," Patterson said. He plans to develop a network of physicians able to provide reliable services so that the Office of Rural Health can guarantee *locum tenens* relief to rural physicians, aiding in efforts to retain them in medically needy communities. By sharing *locum tenens* assignments among many different physicians, the program also will stem burnout among its own ranks of itinerant physicians.

In addition, Patterson hopes that the *locum tenens* doctors serving in the Office of Rural Health program might one day become full-time physicians in rural North Carolina. The program itself can become a recruitment pool in that visiting physicians may decide to settle in one of the communities they serve.

As stated earlier, *locum tenens* services can become a valuable tool to help promote the retention of physicians in rural underserved areas. *Locum tenens* also can play a part in recruitment by giving new recruits the security of a future potential resource for obtaining important coverage. In addition to these goals, the *locum tenens* services can 1) provide needed relief for community-based physicians; 2) develop a rural primary care resident educational experience for residents and fellows in training programs; and 3) develop a supportive link between academic and community physicians. Until a "cure" for the recruitment and retention of primary care physicians is discovered, the primary health care system in rural North Carolina will remain fragile. Affordable *locum tenens* services help to solve the problem of attracting and retaining doctors in rural isolated areas.

III. ACCESS

B. WORKFORCE ISSUES

1. ACCESS AND WORKFORCE ISSUES IN NORTH CAROLINA

The volcanic changes that are occurring at lightning speed in the health care delivery systems across the state have great potential for dramatic shifts in the health care workforce. With the emphasis on controlling health care expenditures, decreasing hospital days, fewer procedures, and more preventive care, the types and mix of individuals in the workforce will need to accommodate these changes. These market shifts toward managed care and hospital mergers are having a dramatic effect on the way medicine is practiced and are beginning to influence how health professionals are trained. Sound public policy should anticipate these alterations and change funding streams in a way that professional schools are strategically poised to provide an appropriate workforce for the future.

The question that looms on the horizon is whether the supply of primary care providers is adequate to support managed care, especially as Medicaid joins the HMO fray. A few years ago there was little impetus to move in the direction of limiting the number of specialists while increasing the number of primary care doctors, nurses, and physician assistants. Today, competition among managed care organizations, threats of reduced funding of medical education, and an overall push to cut costs have proven to be strong motivators for changing the direction of training health care providers.

In keeping with the direction from the General Assembly that the Health Care Reform Commission monitor market reform activities in the state the Commission, through funding from the Robert Wood Johnson Foundation, contracted with the Cecil G. Sheps Center to assist the commission in projecting health workforce needs for the state.

What follows here is a report on the findings of their study as presented by Dr. Thomas Ricketts to the Commission.

There is a growing perception that there is a serious oversupply of physicians in the United States and that oversupply is concentrated among specialists and in many urban areas. The spread of managed care and integrated systems has created a growing demand for primary care providers nationally and in North Carolina. North Carolina has areas of the state where there are severe shortages of primary care physicians and providers and other areas where existing providers are experiencing heavy demand. The four medical schools, their affiliated primary care training programs, the statewide AHEC system and the Office of Rural Health with the support of the General Assembly have expanded programs to increase supply and have created support systems to retain primary care providers in the state. However, the market for primary care health professionals functions at a national level, and North Carolina, alone, cannot fully meet the needs of all its underserved population without very strong policy changes that would seriously modify the market. Estimates based on existing demand for services and accounting for expansion of the managed care market show that North Carolina has an immediate shortage in underserved areas of a minimum of 100 primary care providers and, with the expansion of managed care in the state, that this shortage will grow to as high as 800 providers by the year 2010. Options for the state to address these issues include expanding existing training programs for primary care, assisting the transition of specialists into primary care practices, providing continued or expanded support for community based primary care professionals, modifying the licensing laws to require practice in underserved areas prior to full licensure, and adapting the licensing laws to allow for network or institutional control over practice scope.

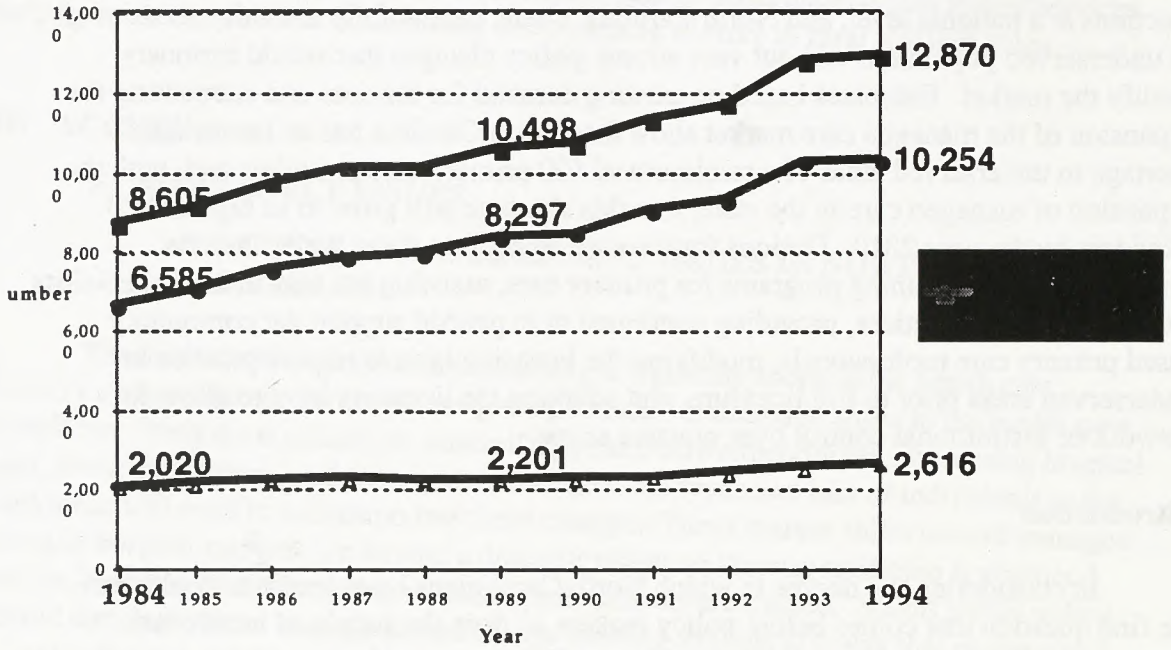
Introduction

In considering the degree to which North Carolinians have access to health care, the first question that comes before policy makers is: does the supply of health care professionals meet the needs of the population? This report addresses that question for primary care providers—generalist physicians, physicians assistants, and nurse practitioners.

North Carolina's Practicing Physicians

The overall supply of practicing physicians in North Carolina has shown a steady increase since 1980. In 1980, there were an estimated 7,328 active, non-federal, non-resident-in-training physicians with a primary location in North Carolina and by 1994, the number has increased to 12,870 which is a 76% increase. There was a 50% increase in the number of physicians over the past ten years, 1984 to 1994 (see Figure 1 below). This increase was mostly spurred by the 56% increase in physicians in metropolitan counties while there was a 30% increase in the number of physicians in nonmetropolitan areas. The total supply, based on these trends, will grow to 16,416 by the year 2000.

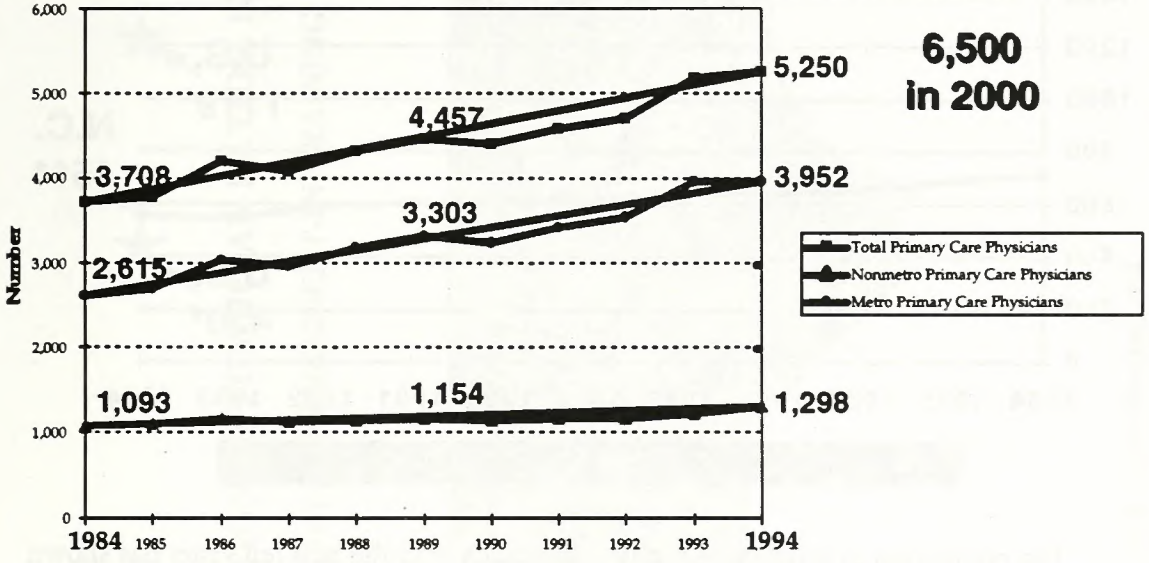
Figure 1. Trends the Active Physician Supply in North Carolina, 1984-1994



For comparison, a chart of the trends in primary care physicians over the same period shows similar patterns of change with a slightly higher rate of increase in rural counties. The number of primary care physicians in North Carolina increased by 58% between 1980 and 1994 from 3,327 to 5,250 providers. Over the past 10 years, there has been a 42% increase in primary care physicians with 3,708 primary care physicians in 1984. Most of the growth in providers was due to the increases in metropolitan areas where the number increased 51%. There was little increase in the number of primary care providers in nonmetropolitan areas over the past ten years with less than 20% increase.

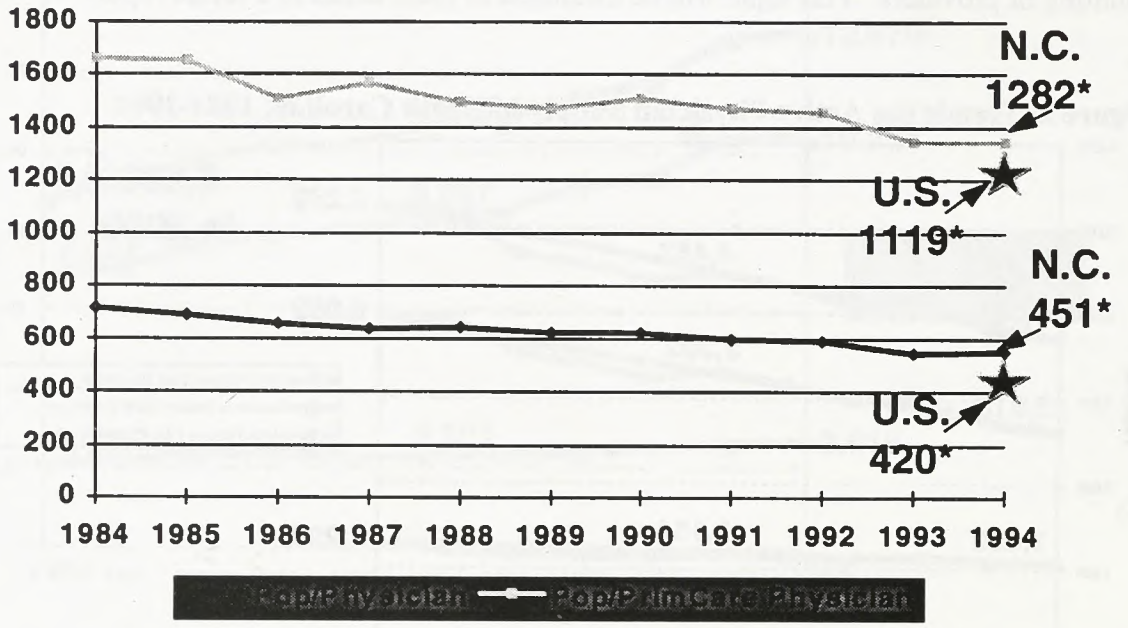
As of 1994, the distribution of primary care to specialists physicians in North Carolina, based on primary locations, is a 41% to 59% mix. This is comparable to the national distribution- 36%-41% of the physician workforce is practicing primary care (Kindig 1994, AMA 1994). Note that definitions of primary care can influence the counting of providers. This topic will be discussed in more detail in a future report.

Figure 2. Trends the Active Physician Supply in North Carolina, 1984-1994



From the figure above it is easy to see that there are differences in the urban and rural physicians supply. To determine if there are access problems caused by this static rural supply, we must examine the changes in population that are occurring simultaneously. In Figure 3 it can be seen that the ratio of population-to-physician for non-metropolitan areas does show a marked downward trend (improvement) in recent years. This figure uses AMA Physician Masterfile data in order to compare North Carolina's ratio to the national ratio. Using the North Carolina Medical Board's license data we calculate the population-to-primary care primary care ratio to drop to 902:1 in 1995, this ratio will continue to fall in the coming years under current conditions.

Figure 3. Population-to-Physician and to-Primary Care Physician Ratios, North Carolina, 1984-1994 (AMA Data)

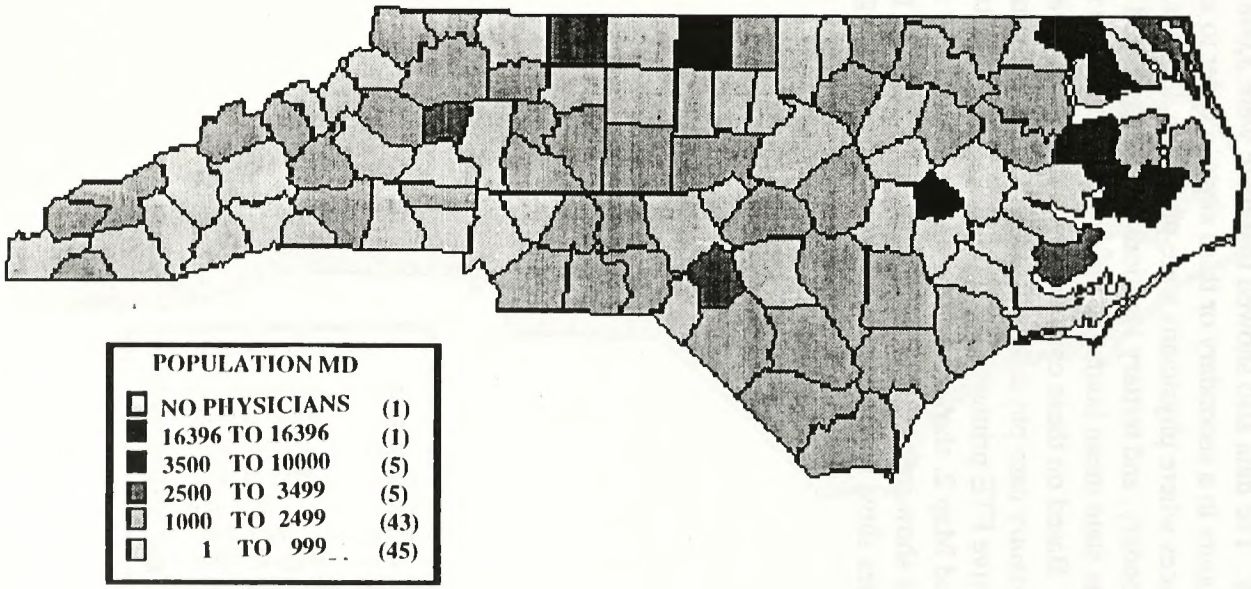


The population to primary care physician ratios over the past ten years has shown more flux than the population to physician ratios but overall there has been a significant decrease in the population to primary care physician ratios with a total 19% decrease (improvement) in the ratio; metropolitan counties improving by 21% decrease and nonmetropolitan by 9%.

There is however extreme variation in the numbers and ratios of physicians among the 100 North Carolina counties. The map below shows this distribution graphically; the "core" metropolitan counties have much better ratios that the rural eastern and mountain counties.

NORTH CAROLINA POPULATION TO PHYSICIAN RATIOS, 1994

ACTIVE, IN-STATE, NON-FEDERAL, NON-RESIDENT-IN-TRAINING



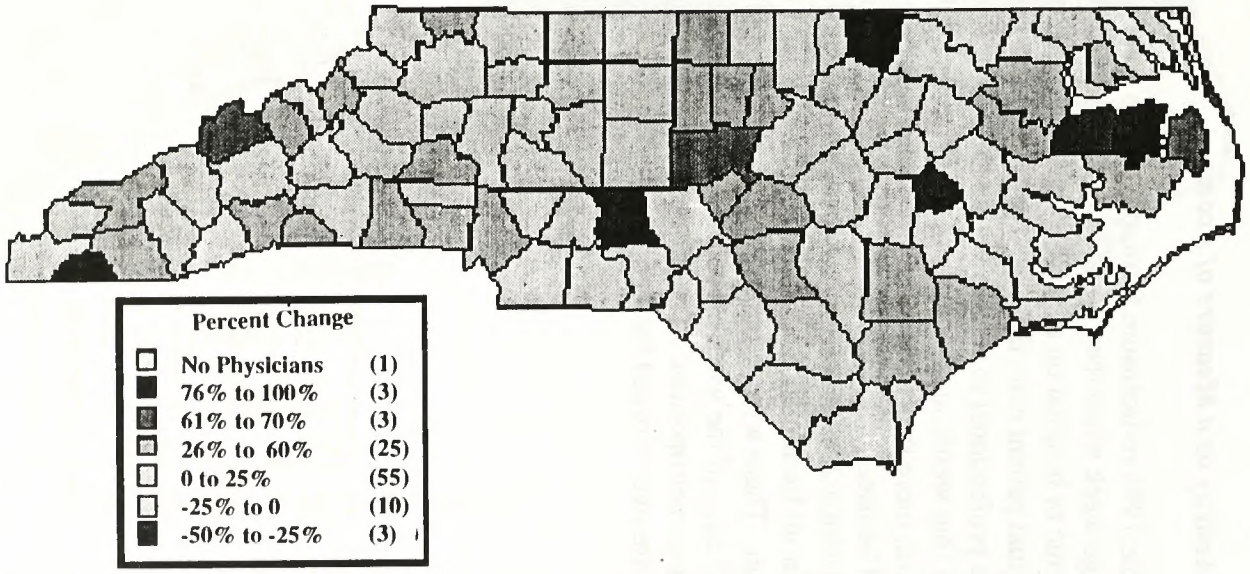
Source: Log Into North Carolina (LINC), Office of State Planning, 1994;
North Carolina Medical Board, October, 1994; compiled by Cecil B. Sheps Center for Health Services Research
Produced by Cecil G. Sheps Center for Health Services Research, University of North Carolina at Chapel Hill

The Problem of Counting Physicians

The numbers presented above reflect counts of physicians based upon the single location of the licensee and accepting all physicians as equal as full-time providers. In 1994 the North Carolina Medical Board, on its re-licensure form, asked physicians to provide the number of hours spend providing various activities in up to three locations. These data were examined by the Sheps Center to determine the actual number of hours that physicians spent in up to three practice locations providing direct patient care, teaching, research, administration and other activities (on-call hours were excluded). This analysis found that, overall, physicians provided and average of 53 hours of patient care per week. The data also showed that there were 3,048 physicians reporting active patient care hours in a secondary or third site. In order to allocate physician practice to the actual places where physicians were providing services, the number of hours in primary, secondary, and tertiary locations were aggregated across counties and then divided by the state mean hours (53) in order to determine the total number of FTEs in each county. Based on these calculations, there would be an overall 24% decrease in the number of *primary* care physicians using this FTE-adjustment for hours from 4301 to 5350 total active FTE primary care physicians. The adjustment affects counties differently and Map 2. shows how this changes the supply in each of the counties. Some rural counties show increases in their supply as secondary practice locations are included. Urban counties show net losses which are reflected in the gains by surrounding counties.

PERCENT CHANGE IN POPULATION TO PRIMARY CARE PHYSICIAN RATIO WHEN ADJUSTING FOR SECONDARY AND OTHER PRACTICE LOCATIONS, 1994

ACTIVE, IN-STATE, NON-FEDERAL, NON-RESIDENT-IN-TRAINING NORTH CAROLINA COUNTIES



* Full-Time Equivalent adjusted to state mean

NOTE: Primary Care Physicians include those physicians with a primary specialty of family practice, general practice, internal medicine, obstetrics, gynecology, or pediatrics

Source: North Carolina Medical Board October, 1994;
compiled by Cecil G. Sheps Center for Health Statistics, Research, U.S. Bureau of Census, 1994
Produced by Cecil G. Sheps Center for Health Services, Research, University of North Carolina at Chapel Hill

Map 2. Population-to-Primary Care Physician FTE Ratios After Allocation of Secondary and Tertiary Location Data, North Carolina, 1994

This decrease in the count of physicians indicates that reliance on the head count of physicians' primary location may misrepresent the real supply and distribution trends in North Carolina because it does not account for the hours spent in the various activities nor does it reflect the hours spent in other locations. The net reduction in FTEs may also indicate that there is a much more severe shortage of primary care physicians that previous analyses were able to indicate.

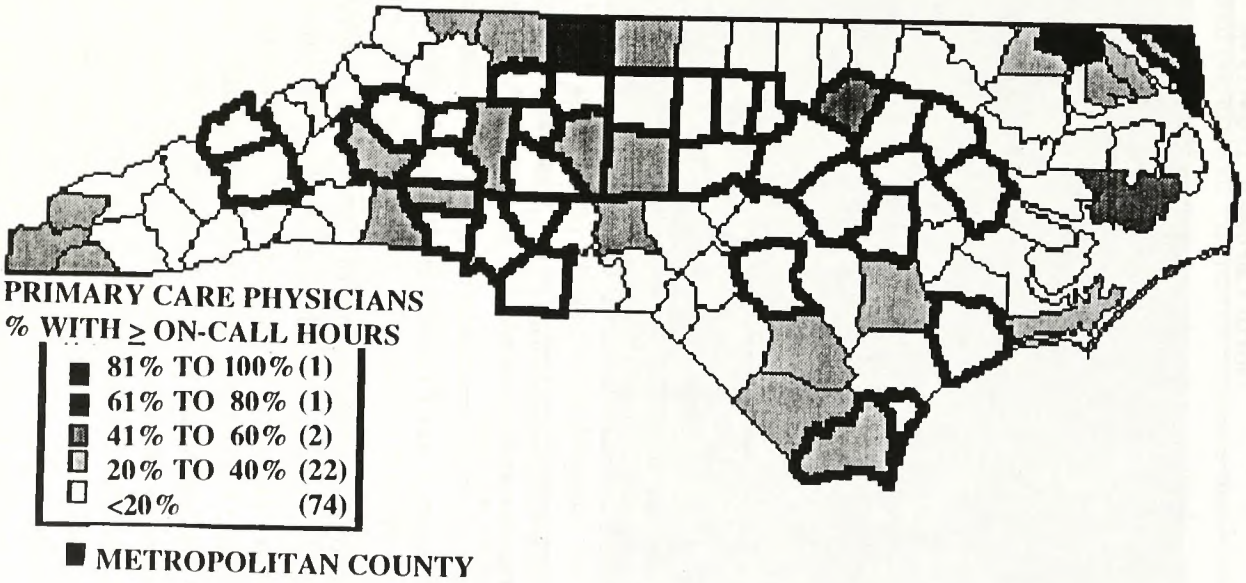
The data used to more accurately describe the supply and distribution of physicians in the state used in this analysis were available only for the year 1994. The North Carolina Medical Board has revised their re-licensure form to remove the information concerning multiple locations and practice hours. These data are necessary for any accurate assessment of the locations of providers and estimates of needs across the state.

Physician Activity as a Measure of Access

In the 1994 re-licensure form, physicians were asked to report the number of hours in an average week when they were on-call or required to be responsive to any need for care in a clinic or hospital on a stand-by basis. While on-call hours may or may not be filled by actual patient care, the time a provider is on-call restricts their other activities and requires the professional to remain within the practice community or site and not engage in activities that would not allow them to answer immediate requests for their services. Counties with more than 20% of its physicians spending more than 3 days on-call per week could be used as an indicator of underserved communities. There were a total of 26 counties in which 20% of the primary care physicians were on-call over 3 days a week, adjusting for all locations. Sixty-nine percent (69%) of these counties were classified non-metropolitan. There were a total of 31 counties in which 20% of other specialists spent more than 3 days of the week on call. Eighty-one percent (81%) of these counties were classified non-metropolitan. Therefore, a disproportionate number of non-metropolitan physicians are over-worked based on this analysis.

NORTH CAROLINA COUNTIES WITH 20% OR MORE OF PRIMARY CARE PHYSICIANS INDICATING ≥ 73 ON-CALL HOURS, 1994

ACTIVE, IN-STATE, NON-FEDERAL, NON-RESIDENT-IN-TRAINING



NOTE: Primary Care Physicians include those physicians with a primary specialty of family practice, general practice, internal medicine, obstetrics, gynecology, or pediatrics

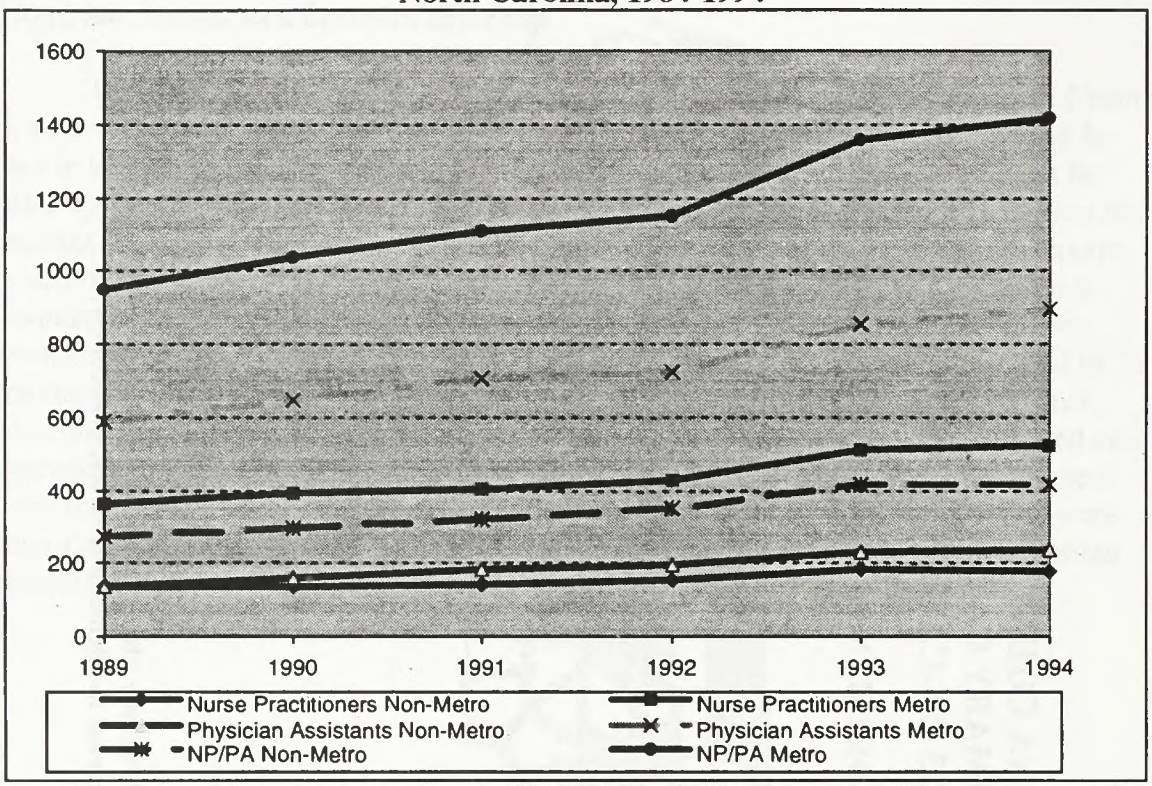
Source: North Carolina Medical Board October, 1994;
compiled by Cecil G. Sheps Center for Health Statistics, Research, U.S. Bureau of Census, 1994
Produced by Cecil G. Sheps Center for Health Services, Research, University of North Carolina at Chapel Hill

Map 3. Counties with 20% of Physicians On-Call for More than 72 hours per Week

Nurse Practitioners/Physician Assistants

The number of nurse practitioners and physician assistants has increased dramatically over the past ten years, especially in the last two years. There has been a 65% increase in the number of nurse practitioners and 117% increase in the number of physician assistants between 1984 and 1994. Between 1992 and 1994 there has been a 20% increase in the number of nurse practitioners and a 23% increase in the number of physician assistants. Figure 5 indicates trends in the supply of physicians assistants and nurse practitioners during the most recent decade.

Figure 4. Trends in the Supply of Nurse Practitioners and Physicians Assistants, North Carolina, 1984-1994



Forecasting Primary Care Provider Needs for the State

In order to forecast the supply of the workforce, several assumptions need to be made. In recent years, four methods of estimating the future requirement for physicians have been most-widely used: 1) demand-based forecasting; 2) need-based forecasting; 3) adjusted need-based forecasting; and 4) the extrapolation method. Many assumptions are required about the health care system, the political climate, and social and economic conditions in order to make reasonable predictions about the health professions workforce. For example, assumptions about the insurance status and health status of the general public (such as morbidity, mortality rates, the growth in the number of elderly) as well as the provider population need to be considered. In addition, technological advances in bio-medical sciences and their impact on the longevity of life as well as its

influence on the career path of health professions could play a role in changes in the supply of the health professions workforce. Also, the reorientation of the delivery system to a more integrated team approach that de-emphasizes the role of the physician would reduce the staffing requirements of physicians, especially specialty physicians, and increases the need for mid-level providers (IOM, 1996). According to Weiner (1993), putting a quantitative figure on the impact of (all these) factors on physician requirements is extremely difficult.

Need As Defined by Managed Care

An example of the extrapolation method of forecasting is a model developed by Jonathan Weiner (1994) that relies on the staffing patterns within managed care plans to extrapolate the needs of the overall population. The heavy emphasis that HMOs are placing on NPs and PAs influences the staffing projections. According to national reports, an estimated 60% of all NPs and PAs are practicing primary care. Based on the assumption that 40% to 65% of Americans will be receiving their health care from an integrated managed care delivery system by the year 2000, Weiner predicts that there will be an overall surplus of about 165,000 patient care physicians; 2) the requirement and supply of primary care physicians will be in relative balance but the supply of specialists will outstrip the requirement by more than 60% unless training patterns are modified.

Weiner's projections are based on national estimates and several assumptions. Different regions of the country have varying degrees of managed care market penetration and the Southeast region of the country has significantly less managed care market penetration that other parts of the county. According to AARP (1994), only 6.6% of the total North Carolina population was enrolled in an HMO in 1993 (ranked 36 out of 50 states). Almost 10% (9.9%) of the Medicaid population was enrolled in some sort of HMO arrangement while only 0.4% of the Medicare population was participating in 1993. Weiner's forecast should be used with caution in projecting the workforce requirements of North Carolina health professions because an assumption that 40%-65% of North Carolinians will be enrolled in managed care by the year 2000 seems unlikely. Despite the fact that the enrollment into HMOs has increased significantly in recent years, this large of a jump seems unrealistic.

Applying the HMO-model approach to North Carolina can provide an estimate of the numbers of physicians and other primary care providers the state will be able to support given that the population is served primarily by managed care systems.

Table 1. Comparison of HMO-Based Requirements

HMO RATIOS	Physicians per 100,000			State Requirement 1995 FTE Physicians		
	Generalists	Specialists	Total	Generalists	Specialists	Total
7 Kaiser Plans	54	58	112	3869	4156	8025
Kaiser-Portland	56	81	137	4013	5804	9816
GHA Seattle	57	65	122	4084	4657	8742
GHAA Survey	88	50	138	6305	3583	9888
GHAA Profile	71	61	132	5087	4371	9458
PPRC	62	73	135	4442	5231	9673
Tarlov	66	54	120	4729	3869	8598
High-High	88	81	169	6305	5804	12109
State Supply-NC 1995				5400	7750	13150

For all but one of the estimates of need, North Carolina's current supply exceeds the requirements by substantial size (Table 2). Only the GHAA survey estimate of primary care would show North Carolina to have a shortage of primary care providers while having a very large oversupply of specialists.

Table 2. Excess (or Shortage) of NC Physicians Using HMO Requirements Model

	Generalists	Specialists	Total
7 Kaiser Plans	1531	3594	5125
Kaiser-Portland	1387	1946	3334
GHA Seattle	1316	3093	4408
GHAA Survey	**-905**	4167	3262
GHAA Profile	313	3379	3692
PPRC	958	2519	3477
Tarlov	671	3881	4552
High-High	**-905**	1946	1041

The American Academy of Family Practice (1995) has adapted this managed care requirements model to reflect the actual use of non-physician providers and the teaching, administration and research needs of the nation to create a target ratio of providers and population. The AAFP bases its work on the Council of Graduate Medical Education's analyses conducted by Jonathan Weiner (1994) and reported by Kindig (1994). The scenario supported by the AAFP anticipates that, by 2010, 50 percent of the allopathic physician workforce will be made up of family physicians and that there will be an increase in the number of Osteopathic generalists to 125 percent of current numbers and

nurse practitioners and physicians assistants by 150 percent over the next 20 years to reach a stable supply to cope with a system largely served by managed care.

Using these target ratios as a guide, the requirements for North Carolina were estimated for the current supply situation and for 2000. Table 3 summarizes the results of that analysis.

Table 3. Projections of Need for Primary Care Physicians Based on AAFP Targets

	NC population, 1995 7,165,298	NC population 2000 7,570,332
FP Supply, 1994, NC 1645	FP Requirement 1995(AAFP) **2386** FP Supply, 1995 (projected)=1688 Number required, 1995=**698**	FP Requirement 2000(AAFP) 2520 FP Supply, 2000 (projected)=1732 Number required, 2000=**788**

The analysis indicates a current under-supply of 698 family practitioners if managed care were generally available and a projected undersupply of 788 in 2000. This scenario does not address the ability of other generalists and specialists to provide primary care in a managed care-dominated system. The approach can be modified to adjust for the wider use of other generalist physicians in the system to where they would make up 50 percent of the supply. The requirements for physicians will, under a full allocation of primary care physicians to the 50% ratio, show a balance between supply and requirements in 2010 with a slight oversupply in 2000.

These gross estimates of supply and requirements are often not tempered by an appreciation of the realities of local markets. North Carolina has 65 of its counties currently designated as a whole or part Critical Health Professional Shortage Area (HPSA) for primary care. The number of full-time primary care providers needed to erase those shortage designations is 95. The number needed to bring the counties up to a minimal primary care provider to population level would require 503 FTE physicians currently, 576 in 2000, 642 in 2005 and 719 in 2010 (Kobrinski et al, 1995). These estimates do not anticipate physicians in adequately or oversupplied counties moving into the undersupplied counties. The statewide supply would be adequate if there were shifts of 471 primary care physicians in adequate or over-supplied counties to those with population to provider ratios in excess of 2000-to-one.

III. ACCESS

B. WORKFORCE ISSUES

2. TRACKING HEALTH CARE PROVIDERS

House Bill 230, Sec. 23A.4 requires health professional licensing boards for physicians, physician assistants, nurse practitioners and nurse midwives to submit on an annual basis information to the Health Care Reform Commission to assist in tracking the location and specialties of health care providers to determine current and future shortage areas.

In order to comply with the above requirement, Dr. Jim Jones will convene a meeting of representatives from the Medical Board, the Board of Nursing and the Sheps Center for the following purposes:

1. to review the data currently collected and the timeframe for collection;

2. to identify data required to adequately track primary care health professionals; and

3. to establish a plan and schedule for future collection and analysis of the data.

The proposed meeting will complement the presentations on workforce by the Medical Board and the Board of Nursing at the January meeting and Dr. Ricketts' discussion on preparing to meet the health care workforce needs in North Carolina presented at the February Commission meeting.

THE MEDICAL SCHOOL DEANS

In fulfilling its charge to ensure that the state had an adequate number of primary care providers for the future the Commission requested reports from the deans of the 4 medical schools in the state. Speaking on behalf of all medical school deans, Dr. James Hallock, dean of the ECU School of Medicine emphasized the following points:

- The four medical schools are responsible for medical student and resident physician education.

- The schools do a remarkable job and educate 70% of all North Carolinians in medical school and over 50 percent of the physicians in the state.

- We are dedicated to training increased numbers of generalist and primary care physicians. We partner with AHEC in this pursuit. all are serious about commitment to work with the state regarding the appropriateness of the physician workforce.

- Educational programs have a wide spectrum of funding sources but include state and federal dollars including Medicare. We are concerned that health care reform and managed care do not address dollars for education.

- All of the schools and hospitals care for indigent or uninsured patients who come to us. We are all interested in increasing delivery, access to care for the underserved and in eastern North Carolina, the rural patient.

- Medicaid changes should be directed in such a way that there is not harm to the schools of Medicine. We are all very concerned that we not repeat the experience of Tennessee. If we need to adjust we will, but we must be sure we don't injure the academic integrity of our Schools and their ability to train.

- We wish to participate in every way possible and to compliment the Commission for its attention to this issue of access.

Dr. Hallock also offered the Commission the full cooperation and partnership of the four deans of the Medical Schools to resolve the access problems, offering to form a subcommittee to assist in any deliberations the Commission may have on this topic.

He then introduced the Dean of the Duke School of Medicine, Dr. Ralph Snyderman and the Dean of The Bowman Gray School of Medicine, Dr. James Thompson who elaborated on his comments and personally extended their offers of assistance. Both deans outlined the efforts of their schools of medicine to be active participants in their communities. Dean Snyderman pointed out that Duke, in an effort to prepare for anticipated market changes had begun its downsizing process, costing over a thousand jobs to the community as a result. Dean Thompson said, "We are working hard to find ways to reduce the costs of delivering health care to our patients. However, in a price competitive market, academic medical centers can be underpriced because they carry the burden of increased costs relating to education and training, and research and to the treatment of more severely ill and underinsured patients. Each provider in the system plays a unique role. Our concern is that the proposals currently on the table (in Washington) do not take this into consideration." Dean Thompson pointed out that Baptist Hospital's payments from Medicare could result in cuts which would reflect payments between 13% and 38% below the hospital's cost of care.

ALLIED HEALTH

The Commission heard from Dr. Robert L. Thorpe, representing the Council for Allied Health in North Carolina, regarding a comprehensive report compiled by the Council which summarizes the issues, needs, priorities, and recommendations related to developing an allied health workforce in the twenty-first century. The executive summary of this report is included as Appendix H.

It is the Council's position that across North Carolina, hospitals, home care agencies, nursing homes, public health departments, and schools have shortages of qualified allied health personnel.

The occupation with the highest vacancy rates, physical therapy, was most frequently reported as taking over 90 days to recruit. Occupational therapists, speech/language pathologists, and physician assistants were also identified as professional groups that were difficult to recruit in North Carolina.

Given the integral role that allied health professions play in health care, and given that allied health professions comprise from one-third to two-thirds of the health care workforce, the Council "urges that North Carolina's policies and actions on health care reform and health manpower development take these occupations into account."

IV. OTHER

A. OTHER ASSIGNMENTS

The North Carolina General Assembly assigned a lengthy list of areas for study to the NC Health Care Reform Commission. Many of those items are addressed elsewhere in this report. Some of these items are slated for study in the coming months. The items which are included in this report for current study yet are also slated for further study include: cost containment efforts; accessibility to health care in rural and medically underserved areas; availability of affordable health insurance for small businesses, including the Health Care Purchasing Alliances; efforts to increase the purchasing power of government health programs; the number of persons who lack access to primary care providers; trends in the numbers of uninsured and underinsured persons and barriers to access by these persons; the impact of federal budget decisions on underserved and underinsured populations; and the number of persons who lack access to primary care providers.

Also under study are these measures: development of methods to ensure adequate primary care services for all eligible residents and appropriate compensation for primary care services to achieve that end; the review and identification of initiatives and incentives to enhance the practice of primary care medicine in rural areas of the state; the identification and/or development of incentives to encourage diversification in health care facilities in rural and other areas of the state; the development of alternative ways to expand coverage to uninsured persons.

The Public Health Study Commission has been asked to study and report to the Health Care Reform Commission on a number of issues including: the role of the existing county health care systems in the health reform effort; the need for additional benefits and population-based services to be offered in the community based on the established

priorities for improving health status in the community and the effectiveness of different types of preventive health services.

Additional items which are slated for study include: an examination of the roles of other existing publicly financed systems of health coverage such as Medicare, federal employee health benefits, health benefits for armed services members, the Veteran's Administration, the CHAMPUS program and any other health benefits currently mandated by State or federal law or funded by State agencies; the means by which the delivery of health care will ensure that the needs of special populations of eligible residents such as low-income persons, people living in rural and underserved areas, and people with disabilities or chronic or unusual medical needs will be met; the appropriate means of financing medical education and medical research; the means by which North Carolina's need for long-term care services can best be met, including an examination of the appropriateness and availability of home and community-based services; the impact on health care costs and efficiency of rule changes made by State and local government agencies pertaining to health care services, including the frequency of such rule changes; privatization of administrative, clinical and mental health functions performed by governmental agencies and entities; incentives for increasing employer-based coverage; and, ways to maintain emergency medical services when hospital beds are reconfigured.

IV. OTHER

B. HEALTH INFORMATION

The fundamental basis of modern health reform is market-based reform which is consumer driven. In order for individuals to make sound, educated informed choices about who he or she wants to have as a provider, the individual needs information. As a crucial function of a sound public/private partnership and of solid market-based reforms, a sound health information policy needs to be on the front burner of the health care reform debate. This is one of the big issues facing legislators as health policy decision makers.

In collecting health information, the assurance of the collection of timely, reliable and relevant information is an obligation of the public/private partnership. The current system of information, collection, analysis and dissemination is very fragmented. North Carolina has some excellent examples of programs that work, but from a systemic point of view, it is a fragmented system. Efforts are currently underway to make North Carolina's health care policy information systems a lot less fragmented.

For far too long our efforts were tied to an outmoded delivery system and failed to respond to the acceleration of change in the delivery system. These changes are occurring at a tremendous rate and have wide impacts throughout the entire state. North Carolina needs to examine methods of collecting information to assist health policy makers in both

the private and public sectors to base decisions on current information and future trends rather than systems which have already been abandoned.

Among the groups most in need of reliable, accurate and current data are purchasers, including the state as a large purchaser. All purchasers need to have reliable mechanisms to hold the health care delivery system accountable for the enrollees within the particular system, for other people within the state whom that system impacts and clearly for the very unique responsibilities that a state government holds in terms of responding to the needs of the disenfranchised and people who are underserved within the state. One of the leading projects underway nationwide is the bringing together of business purchasers, state policy makers and state purchasers. These purchasers are in the position of pushing forward the agenda of accountability in both terms of cost containment and in terms of quality -- which in their minds equals value. These groups have certain agreed upon principles:

- to support local and state level health care information initiatives and oppose a federal one-size-fits-all solution. Each state is unique by virtue of its environment, its delivery system and its own need to work with its own business community to develop its own information project

- it is important to identify and prioritize the enormous amounts of health care information that different users need to have to meet their responsibilities. Providers face a growing need for information for quality outcomes and quality assurance, cost comparisons, etc., that threaten to tie up practices in a constant barrage of demands for information

- health information is evolutionary, not static, and it is going to change as states and the private sector work within the delivery system and the market to meet changing demands in a changing environment.

Requests for information are moving away from the traditional cost and charge information requests to the requests that are able to document value defined as a combination of cost and quality so that outcomes information becomes available to show whether or not policy changes cause health status to improve. This kind of information can help purchasers and consumers capture the value with the dollar as they purchase health care coverage.

The Commission took only an initial look at this subject and plans to revisit it and study it in greater depth and to make future recommendations.

V. SPECIAL REFERRALS

A. REFERRALS FROM THE 1995 STUDIES BILL

The North Carolina Health Care Reform Commission was authorized in Chapter 542 of the 1995 Session Laws, Section 12.1(9), House Bill 898, to study the following topics:

1. May study Medicaid and medical cost containment in order to develop a medical cost containment policy that ensures that appropriate medical care is delivered in a cost-effective manner.

2. Shall study the methods of financing immunizations services and the impact of the methods on age-appropriate immunization rates and other immunization programs.

3. Shall study the issue of fees for copies of medical records.

The Commission may make an interim report to the 1996 Regular Session of the 1995 General Assembly and shall make a final report to the 1997 General Assembly upon its convening. For each issue, the original bill may be considered in determining the nature, scope, and aspects of the study. As reported below, the Commission has initiated studies in all three areas.

1. IMMUNIZATIONS

During the 1995 General Assembly session, Senate Bill 1044, Vaccine Program/Savings, was introduced by Senator James Speed. Senate Bill 1044 which would have changed the Vaccine Program to prohibit health care providers who receive free vaccines from providing such vaccines to patients with health insurance coverage for full cost of these immunizations did not crossover. However, the 1995 Studies Bill requires that the NC Health Care Reform Commission study immunizations. The Commission initiated its study by hearing from interested and concerned parties at its December 14, 1995, meeting.

Dr. Ronald Levine, State Health Director, presented information on the state's immunization program. He stated that immunization is the single most effective individual health service known to man. North Carolina has a universal vaccine distribution program which removes the barriers of rising vaccine costs and allows children to receive their immunizations in their regular doctor's office instead of the local health department. As a result of implementation of the 1993 legislation establishing the Vaccine Program, North Carolina has this year ranked as having the fourth highest immunization rate in the nation. The table below compares coverage rates for selected age groups before and after the implementation of the Vaccine Program.

STATEWIDE IMMUNIZATION COVERAGE ESTIMATES			
Comparison of Immunization Coverage Rates before and after Universal Child Vaccine Distribution program for selected age group			
Age: Assessment criteria	COVERAGE ESTIMATES		% change
	Children Born in Dec 1991 (before UCVD)	Children Born in Jan 1994 (after UCVD)	
3 months: 1 DTP, 1 Polio	86.8	89.3	+2.8
5 months: 2 DTP, 2 Polio	74.3	80.3	+8.1
7 months: 3 DTP, 2 Polio, 3 Hib	53.9	62.5	+15.9
Source: Final Report -Immunization Surveys of North Carolina Parents; Sept. 1, 1994 - January 31, 1995 by Dr. Kristen Weigle.			
Comparison of Immunization Coverage Rates for 24 month-olds			
Age: Assessment criteria	COVERAGE ESTIMATES		% change
	Children Born in Dec. 1991 (Parental Survey)	Children Born May 1991-August 1993 (Random Digit Dialing)	
24 months: 4 DTP, 3 Polio, 1 MMR	77.9 ±4.6*	83 ±5.0**	+6.5
Sources: *Final Report -Immunization Surveys of North Carolina Parents; Sept. 1, 1994 - January 31, 1995 by Dr. Kristen Weigle. ** National Immunization Survey, United States: April 1994 - March 1995. MMWR, February 23, 1996- Vol 45(7):page 141-150.			

In response to the suggestion that has been raised by some in the pharmaceutical industry that the state discontinue supplying vaccine to private doctors and clinics for those patients adequately insured, Dr. Levine said that the Department does not support such a change at this time. He said that it is difficult to accurately estimate how many children are insured in North Carolina, and of those insurance policies that cover immunizations, most require a deductible and copayment with the end result being that insurance almost never picks up all the charges for children's immunization.

Mr. Joseph Carlson, retired Director of Government Affairs for Merck's pharmaceutical division and retired Director of US operations of the Merck Vaccine Division and presently serving as a consultant to Merck Pharmaceuticals, addressed the Commission. Mr. Carlson said that the North Carolina immunization program is exemplary and that his presentation is only to ask the Commission to examine the effect of a policy that pays for vaccines which would have been paid by private insurance and to examine the fairness of a policy that taxes citizens paying health care premiums for the same benefit, and to also examine it from an anti-business aspect. He urged the Commission to make a recommendation to exempt fully insured children from the program.

Mr. Bruce Kaylos, plant manager of Wyeth-Lederle in Sanford, North Carolina reported that his company had located in North Carolina because of a favorable business

climate. He wanted to ensure that the Commission was aware that the universal vaccine purchase program as currently constituted represents a clear and present danger to the viability of private vaccine manufacturers and seriously hampers research and development and that translates directly into little hope for the introduction of new life-saving vaccines in the future.

Commission member Dr. Robert Harris, representing Healthsource, said in his presentation to the Commission that the subject under discussion was larger than the immunization issue because it impacts quality of care and part of that is preventive care. He said that at Healthsource the immunization rate is at 95%, and that HMOs are committed to the immunization program. He also said that HMOs are also not wanting to deal with the hassle factor of administrative costs. He said that at present premiums are flat, but if the state vaccination program is discontinued that would no longer be the case. Dr. Genie Komives Associate Medical Director, Carolina Permanente Group, supported the funding of the immunization program and urged its continuance in its current format.

Commission member and President of the North Carolina Academy of Family Physicians Dr. Thomas Newton reaffirmed both his support of the immunization program and the fact that his practice would be unable to handle private insurance administrative costs should the program change. He said that immunization is a prevention program that work and that dollars spent are more of an investment than an expenditure. Dr. David Tayloe, of Goldsboro Pediatrics and President of the North Carolina Pediatric Society, addressed the Commission. He heartily endorsed the present immunization program stating that one reason the program is so popular with both public and private health care provider is its simplicity with one vaccine supply for almost all patients. Both Dr. Newton and Dr. Tayloe said that they would continue to immunize the Medicaid children but would have problems with the privately insured and think that there would be a large number of privately insured going to the public health department. Dr. Freed of UNC reported that a study funded by the Center for Disease Control indicated that physician participation in the program would drop increasingly with increasing physician burden of administrative costs.

After discussion it became apparent that there is a lack of good data as to the insurance status of the children being served by the immunization program. The Commission requested that the State Health Director, with the assistance of the Insurance Department and the resources of Duke and UNC-CH, conduct a study of this issue within the next six months and to present this information to the Commission and General Assembly. Commission members discussed including in the study an assessment of where the money for immunization is being spent and which children are being immunized, the cost of administering the vaccine, the costs to the pharmaceutical companies to produce the vaccine and what they charge for it. Dr. Levine said that insurance data is not available and would be very useful before making any changes in the program.

At its February 28, 1996, meeting, the Commission passed a formal motion to recommend to the 1995 General Assembly that the immunization program and services

established under Part 2 of Chapter 130A of the General Statutes be continued as currently administrated by the DEHNR and local health departments, and that State funding for the program should continue to be provided at levels sufficient to ensure that the original purposes and intent of the program are accomplished. Both the Department of Insurance and the State Health Director will continue to study the program and will report their results to the Commission.

2. FEES FOR COPIES OF MEDICAL RECORDS

During the 1995 General Assembly session, House Bill 741 was introduced to amend the General Statutes which establish the statutory cap on charges for processing medical record copy requests. The bill was last assigned to the Natural and Economic Resources Subcommittee of the House Appropriations committee where it remains. The 1995 Studies Bill directs that the NC Health Care Reform Commission shall study the issue of fees for copies of medical records. At its February 28, 1996, meeting, the Commission heard testimony supporting the proposed change and in favor of retaining the existing language.

Current legislation at G.S. 90-411 allows a health care provider to charge a fee to cover the costs incurred in searching, handling, copying, and mailing records to the patient or the patient's representative. The maximum fee is set at fifty cents per page with an allowable minimum fee of up to $10. The proposed change in House bill 741 would have allowed a health care provider to charge up to $15.00 for search and retrieval, $1.00 per page for copies made from paper and $2.00 per page for copies made from microfilm, plus actual postage and shipping fees and sales tax, if applicable. Neither the current or proposed change allows a charge for copies sent to the patient's provider for the purpose of continuing medical care.

Ms. Betty A. Hall, Southeastern Regional Medical Center, Lumberton, NC, member of the NC Health Information Management Association, spoke from over 30 years of experience in medical records. She reported that the volume of requests for information for non-health related purposes has burgeoned during that period. Where one staff person could handle the volume as part of regular duties in the 1960's, now it takes two and a half full time positions to just keep up with the number of requests. She expressed their willingness to provide health related information to patients for continued care as part of regular business practice. Issues she identified with the current legislation were that it does not allow for increase in the cost of supplies such as paper and Xerox machines, and it does not allow for any increase in labor costs. With the increasing volume, providing copies of medical records has become very labor intensive. Further, Ms. Hall contends that the cost of producing a page of information is greater than $ .50 per page, the results of a recent survey showed the cost to be greater than a dollar on average, with a range from $ .85 to $1.68. Ms. Hall closed her presentation by requesting that the Commission support an amendment to the current legislation to eliminate the $ .50 limitation and to allow providers to charge a "reasonable fee." Dr. Verne C. Lanier, Jr., a sole medical provider, also spoke of an ever-increasing burden of complying with

requests for copies of medical records including labor costs and costs associated with materials, equipment, and postage. Speaking for himself, Dr. Lanier urged the Commission to amend the current legislation and to permit health care providers to charge a fair and reasonable fee.

Ms. Susan Valauri, a registered lobbyist for Nationwide Insurance company, spoke in opposition to changing the copying charges for medical records. Ms. Valauri was a major proponent of the current legislation when it was passed in 1993. She reported that in 1992 Nationwide identified that the cost of copies of medical records was a growing expense line and charges ranged from $7.00 a page to more than $24.00 a page excluding an outlier high of $125 per page. She stated that this is a monopolistic service, in that only the health care provider can furnish copies of the patient's medical records. On reviewing what was done in other states, she learned that many states controlled these costs through legislation. Working with other interested parties, legislation was introduced, amended and finally ratified to establish the uniform $ .50 per page charge and the allowable $10.00 minimum. Ms. Valauri reported that Nationwide, as an insurance company, is willing to pay a fair price for required copies, but it isn't fair for the system to cost-shift to the insurance industry the total cost of a medical copying operation. Since reasonable people can disagree on what a reasonable charge is as evidenced by her testimony, she does not support taking out the statutory cap and putting in "reasonable fee."

3. MEDICAID COST CONTAINMENT

Even without the charge to study, as a major source of insurance coverage in NC, the Health Care Reform Commission has a great concern and interest in the issues of Medicaid. The Commission heard a report from Ms. Barbara Matula, director of the NC Division of Medical Assistance, at its first meeting. Ms. Matula briefed the Commission on both the growth of the program and the proposed federal changes. Commission member Representative Theresa Esposito co-chairs a Blue Ribbon Task Force on Medicaid. The Task Force charge is very broad including becoming fully aware of federal action on Medicaid and its repercussions across NC and developing a plan to reform Medicaid as needed including statutory language. Representative Esposito invited the chairs of Commissions and committees with related activities would be asked to attend the January 4, 1996, meeting of the Task Force so all could be briefed at the same time and activities could be coordinated to minimize overlap in effort. The Commission will continue to work closely with the Blue Ribbon Task Force on Medicaid.

B. REFERRALS FROM THE LEGISLATIVE RESEARCH COMMISSION

The Legislative Research Commission was authorized in Chapter 542 of the 1995 Session Laws, Section 2.1, House Bill 898, to study the issues of Chiropractic Care and Emergency Medical Services, and in Chapter 507, House Bill 230, Section 7.21 (m) to study the issue of State and Other Governmental Assistance to Volunteer Fire, Rescue and

Emergency Medical Service Units. At its meeting on October 5, 1995, pursuant to G.S. 120-30.17(9), the Legislative Research Commission assigned these topics to the North Carolina Health Care Reform Commission. The letter transferring responsibility for these reports stated that the Health Care Reform Commission may make an interim report (with findings and recommendations including legislation) to the 1996 Regular Session of the 1995 General Assembly by April 26, 1996, and shall make a final report to the 1997 General Assembly by January 3, 1997. Subsequently, the issue of State and Other Governmental Assistance to Volunteer Fire, Rescue and Emergency Medical Service Units was reassigned to the Worker's Compensation Committee of the Legislative Research Commission. The Commission has initiated both studies, however, it is not prepared to make a formal interim report on either at this time.

1. CHIROPRACTIC CARE

The original study of chiropractic care was contained in Senate Joint Resolution 228 introduced by Senator Fountain Odom. The original bill may be considered in determining the nature, scope, and aspects of the study. Senate Joint Resolution 228 stated that the Legislative Research Commission may study issues relating to:

1. The efficient and effective delivery of appropriate chiropractic care;

2. The extensive demand for chiropractic care as well as patient freedom of choice concerning appropriate care;

3. the extent to which public and private hospitals in NC extend practice privileges to chiropractors;

4. The role of chiropractic care in the managed care environment; and

5. The cost-effectiveness of chiropractic care.

Three speakers presented the perspective of the Chiropractic Community on health care reform to the Commission at its February 28, 1996, meeting. Mr. Vance Kinlaw, an attorney for the NC Chiropractic Association, summarized the recent developments regarding the education and licensure of chiropractors. Since 1993, chiropractors are required to have a baccalaureate degree and a four-year degree form a chiropractic college that is approved by the Council on Chiropractic Education. After completing his formal training, an applicant for licensure must pass a national examination and also a State administered examination which bears directly on clinical competency. Once licensed to practice, chiropractors are subject to a very stringent disciplinary code. Mr. Kinlaw stated that there is no effort underway to enlarge the scope of practice for chiropractors; what chiropractors are seeking and would hope to achieve is the elimination of some arbitrary and illogical barriers which are inconsistent with the current law covering the scope of practice.

Mr. Kinlaw provided the following examples of the types of discrimination which chiropractors are seeking to end. General Statute 91-53 allows doctors of chiropractic to practice in publicly funded hospitals, yet only one doctor of chiropractic in the State has admitting privileges in public hospitals. The largest public hospital in Wake County refuses to produce extremity films for doctors of chiropractic, that is x-rays other than spinal films even though treatment of extremities are within the lawful scope of practice. The NC Department of Revenue requires doctors of chiropractic to collect sales tax on the vitamins and nutritional supplements that are dispensed, even though medical doctors that dispense the exact same product are exempt from collecting the sales tax. Mr. Kinlaw closed by restating the chiropractic profession's continual striving to upgrade its education and licensure requirements and strengthen its disciplinary code. Despite those efforts, this profession has been hobbled with arbitrary boundaries that are completely unrelated to chiropractic plans. Doctors of chiropractic object to this arbitrary, illogical discrimination based on prejudice.

Dr. Gene Lewis, doctor of chiropractic practicing in Greensboro, presented facts about the profession and its performance. There are 50,000 chiropractors in the United States and 750 practice in NC. Chiropractors treat 20 to 25 million patients a year with about a million visits daily. Across the nation approximately 155 hospitals have chiropractors on staff, contrasting with only one hospital in NC. Chiropractic is covered by Medicaid, Medicare, Workers Comp, indemnity plans and by many managed care plans. It is a mandated benefit for NC state employees and the armed forces. About 95 percent of patients come in for neuro-muscular-skeletal problems. Chiropractors are tied with family doctors for treating those types of problems with orthopedists being third.

Dr. Lewis described several studies regarding the cost and efficacy of treatment. In 1993, the Canadian government released a study that reported in regard to low back pain there was much more information regarding the efficacy of chiropractic treatment than any other treatment that existed. The University of Saskatoon in Saskatchewan published in the Canadian Family Physician in 1985 that 87 percent of patients with chronic back pain returned to normal with as little as one to three weeks of chiropractic treatment and were still asymptomatic one year later. Rand Corporation, which studies many different treatment modalities in the United States, reported in an on-going independent study that "treatment for back pain with chiropractic care demonstrates the most evidence for effectiveness, of all types of care studied." Initially in a 1990 study and reaffirmed in a 1995 article, medical researchers in England concluded that when compared specifically to medicine and physical therapy, results of chiropractic care were judged to be twice as effective in terms of symptom relief and objective examination findings. The last study reported by Dr. Lewis was the 1994 AACPR study of a number of treatments for low back pain which listed spinal manipulation as one of the safe and effective treatments for acute lower back pain.

With regard to cost effectiveness, several studies were cited including the Utah state board of worker's compensation which reported that chiropractic care cost about one-tenth the cost of medical care when the disability time was factored in. Two studies

in 1992, one by the Virginia Bureau of Disability Economics Research and one by the Medical College of Virginia, essentially reported the same findings that chiropractic care is a lower cost option for some back related ailments. Dr. Lewis also reported many studies indicate high patient satisfaction with chiropractic care. The rate of serious misadventure from chiropractic is low as evidenced by the fact that malpractice insurance runs between an third and a quarter of the lowest for medical practitioners. Finally, Dr. Lewis addressed the issue of more rapid recovery reducing the number of disability days and thus returning to work more quickly as a result of chiropractic treatment.

Concluding remarks were presented by Dr. Paul Eagle, a practicing chiropractor in the Charlotte area. Dr. Eagle reiterated the chiropractic communities concern that they are being thwarted in trying to become an established part of the health delivery system instead of a stand-alone delivery system. He believes that to better serve the patient who seeks chiropractic care, the profession has to become more integrated with medical groups particularly managed care plans and hospitals. Ten years ago, chiropractors saw six percent of the population seeking care for low back pain, today they see 30 percent of those patients. A substantial number of North Carolinians are served by chiropractic care. Dr. Eagle reported that the profession is requesting from the Commission a recommendation that says chiropractic care needs stronger interplay in our health care community and that seeks to eliminate biases that are currently in North Carolina's statutes as well as in the medical community itself.

2. EMERGENCY MEDICAL SERVICES

The original study of emergency medical services was contained in Senate Joint Resolution 1045 introduced by Senator James Speed. The original bill may be considered in determining the nature, scope, and aspects of the study. Senate Joint Resolution 1045 stated that the Legislative Research Commission may study issues relating to the Emergency Medical Services Act of 1973 in order to:

1. Determine whether the EMS Act of 1973 provides the State with the most integrated and coordinated approach to emergency medical care;

2. Determine whether all residents of the State have access to high quality emergency medical services care;

3. Determine what impact the reduction in federal assistance has had in emergency medical care in North Carolina;

4. Determine whether the current structure of providing emergency medical services in North Carolina serves the public in the best, most comprehensive manner; and

5. Determine whether the recommendations of the National Highway Traffic Safety Administration's "Assessment of the Emergency Medical Services in North Carolina" should be implemented.

Bob Bailey, Chief, Office of Emergency Medical Services, presented to the Commission on February 28, 1996. He provided an overview to demonstrate the complexity of EMS issues including a description of how EMS is organized, State oversight, regional planners, county delivered and the funding flow. He addressed the economic, geographic and political reasons that contribute to where the patient is transported and a review of the work of the Task Force on Trauma Systems.

He presented the most critical issues from his perspective as the state administrator of EMS. How the EMS system is incorporated into managed care is a critical issue. Problems experienced in other states include bypassing of the EMS system and failure to cover the cost of EMS without prior approval. Federal block grant reductions would not impact delivery since all federal funds currently flow through the COG's (Council of Governments) and counties cover the expenses of providing EMS. A reduction would affect the COG's regional planning role and training infrastructure (regional EMS libraries and training materials repositories). Reimbursement is a big issue since some areas have only one level of service and some payers including Medicare and Medicaid are rigid about what is considered an emergency and eligible for reimbursement. He outlined the EMS-Children initiatives which over the last several years have been and continue to be an important effort to ensure the EMS needs for children are met. Just this year they have secured or been instrumental in securing $500,000 for EMS-Children. They are also participating as a pilot site in an injury prevention program in the school system.

The Commission members discussed several options as to how to continue the study of EMS but have not reached a resolution.

VI. RECOMMENDATIONS

The February meeting of the NC Health Care Reform Commission was used to craft the beginnings of the annual report of the Commission to the General Assembly. That report will be presented to the NC General Assembly during the 1996 Short Session which begins on May 14. The action taken by the NC Health Care Reform Commission during the February meeting included the passage of three resolutions which read as follows:

A. Resolution Supporting Immunization Program

MOTION 1. Commissioner Robert E. Morrison moves that the North Carolina Health Care Reform Commission recommend to the 1995 General Assembly that the immunization program and services established under Part 2 of Chapter 130A of the General Statutes be continued as currently administered by the Department of Environment, Health, and Natural Resources and local health departments, and that State funding for the program should continue to be provided at levels sufficient to ensure that the original purposes and intent of the program are accomplished. (passes 6-4)

B. Resolution Supporting MSAs

MOTION 2. Representative Zeno Edwards moves that the North Carolina Health Care Reform Commission report to the 1995 General Assembly that the Commission supports the concept of Medical Savings Accounts as an alternative source of funding for health care and recommends that legislation be introduced authorizing the establishment of Medical Savings Accounts. (passes on voice vote)

C. Resolution to allow the Health Alliance to sell catastrophic policies

MOTION 3. Representative Zeno Edwards moves that the North Carolina Health Care Reform Commission recommend to the 1995 General Assembly that legislation be introduced authorizing Health Purchasing Alliances to make catastrophic insurance coverage available to Alliance members. (passes eleven to one).

Appendix A

Agendas for Meetings of the NC Health Care Reform Commission

Agenda for 11/8/95

North Carolina Health Care Reform Commission

10:00 a.m.	Introductory Remarks	Co-Chairs Hooker and Edwards
10:15 a.m.	Introduction of Members of Commission and Comments	Members
10:30 a.m.	Report of Executive Director	James G. Jones
10:40 a.m.	Consideration of a Mission Statement	Members
10:55 a.m.	Tracking Health Reform in North Carolina	Dr. Tom Ricketts
11:25 a.m.	Health Reform Update–The National Picture	Dr. Chris Conover
11:55 p.m.	Current Status of Medicaid Reform	Barbara Matula
12:25 p.m.	Implication for North Carolina Following Congressional Action on Block Grant	Sec. Britt
12:55 p.m.	Planning Retreat Issues	Members
1:10 p.m.	Consideration of Future Meeings	Co-Chairs
1:20 p.m.	Adjourn	

to receive general updates please note the NC Health Care Reform Commission Web Page at
http://www.dhr.state.nc.us/DHR/HPC/

AGENDA
NORTH CAROLINA HEALTH CARE REFORM COMMISSION
December 14, 1995

9:00 a.m.	Welcome and Comments	Carmen Hooker, Co-chair
9:10 a.m.	Consideration of Mission Statement	Ms. Hooker
9:25 a.m.	Report of Executive Director	James G. Jones, M.D.
9:30 a.m.	Health Care in Rural North Carolina: Present and Future	Jim Bernstein Office of Rural Health
10:00 a.m.	Critical Health Care Shortage Areas	Harvey Estes, M.D. NC Medical Society Foundation
10:30 a.m.	Questions and Answers	
10:40 a.m.	Health Care Needs in Eastern North Carolina: Is Primary Care the Answer?	Thomas Irons, M.D., Associate Dean, East Carolina University School of Medicine
11:45 a.m.	Response of the Deans of NC Medical Schools	
12:30 p.m.	Lunch Break	
1:30 p.m.	The NC Immunization Program	Ron Levine, M.D. State Health Director
2:00 p.m.	Questions and Answers/Response Panel on Immunizations	
2:15 p.m.	Drug Industry Perspective	Bruce Kaylos, Wyeth-Lederle Joe Carlson, Merck
2:35 p.m.	Managed Care Industry Perspective	Robert Harris, M.D.
2:55 p.m.	Family Physician Perspective	Thomas Newton, M.D.
3:15 p.m.	Pediatric Response	Dave Tayloe, M.D.
3:30 p.m.	Panel–Questions and Answers	
3:45 p.m.	Small Group Purchasing Alliances in NC–An Update	Robert Joyce, State Health Plan Purchasing Alliance Board
4:30 p.m.	Future Meeting Agenda and Date	Ms. Hooker
5:00 p.m.	Adjourn	

AGENDA

NORTH CAROLINA HEALTH CARE REFORM COMMISSION

January 24, 1996

9:30 am	Welcome	Co-chairs Carmen Hooker and Zeno Edwards, Jr.
9:35 am	Announcements and Comments • Directive to Dr. Levine concerning study of state immunization program	Rep. Edwards
9:40 am	Approval of Minutes	Rep. Edwards
9:45 am	Report of Executive Director	Dr. James Jones
9:50 am	Medical Saving Accounts—The National Perspective	Mr. Jack Strayer, Director of Federal Affairs, Council of Affordable Health Care Mr. Dan Perrin, Executive Director, Business Coalition for Affordable Health Care
10:35 am	Question and Answer Session	Commission Members
10:45 am	Medical Savings Accounts–Proposed Requirements for North Carolina	Dr. Ron Levine, State Health Director
11:00 am	Medical Savings Accounts–A Plan for NC	Mr. Tom Jacks, Deputy Commissioner, Department of Insurance
11:30 am	Question and Answer Session	Members
11:40 am	Medical Savings Accounts—Managed Care Industry Perspective	Mr. Harry Kaplan, Kaiser Permamente
12:00 pm	Commission Discussion of Medical Savings Accounts	Members
12:30 pm	**Lunch Break**	
1:30 pm	Data Collection As It Relates to Health Reform	Ms. Hooker
1:40 pm	Medical Care Data Act Update	Mr. Robert Fitzgerald, Assistant Director, Division of Facility Services
1:50 pm	Report from Center for Health and Environmental Statistics	Mr. Delton Atkinson, Director
2:15 pm	The NC Health Information and Communication Alliance	Dr. Sheron Morgan, Director
2:45 pm	The North Carolina Board of Nursing	Ms. Polly Johnson, R.N. and Practice Consultant
3:05 pm	The North Carolina Medical Board	Mr. Bryant Parish, Executive Director
3:25 pm	Commission Discussion of Health Data	Members
4:00 pm	Adjourn	

AGENDA
North Carolina Health Care Reform Commission
February 28, 1996

9:00 AM	Welcome and Comments	Co-chair Carmen Hooker
9:10	Approval of Minutes of January meeting	Members
9:15	Consideration of Resolutions • Resolution on state immunization program • Resolution on medical savings accounts	Members
9:30	Report of Executive Director	James G. Jones, M.D.
9:35	Medical Records Fee HB 898, HB 741 and SB 545–Legislative Background	Ms. Linda Attarian, M.P.H., J.D., *Staff Attorney, General Assembly*
9:45	Rationale for Changing the Statutory Cap on Charges	Ms. Betty Hall, *Medical Records Officer, SE Regional Medical Center* Verne C. Lanier, Jr., M.D., *Lanier Plastic Surgery Center*
10:05	Rationale for Not Changing the Statutory Cap on Charges	Ms. Susan Valauri, *Area Legislative Affairs Representative, Nationwide Insurance Enterprise*
10:25	Discussion and Recommendations	Members
10:45	Consideration of Chiropractic Care • HB 898 and SJR 228 Legislative Background	Mr. Vance Kinlaw, *Attorney, NC Chiropractic Association* Gene Lewis, D.C. Paul Eagle, D.C.
11:30	Discussion and Recommendations	Members
11:45	Emergency Medical Services • HB 898 and SJR 1045 Background	Ms. Anna Wasdell, *Staff*
11:50	Overview of Current Emergency Medical Services and Critical Issues	Mr. Robert Bailey, *Chief, Emergency Medical Services*
12:30 PM	Discussion and Recommendations	Members
1:00	Lunch	
2:00	Preparing to Meet the Health Care Workforce Needs in NC for 2000 and Beyond	Tom Ricketts, Ph.D., *Staff Consultant, Cecil G. Sheps Center*
2:30	The Role of the North Carolina Area Heath Education Centers in Meeting Workforce Issues	Mr. John Payne, M.P.H., *Interim Director, NC AHEC*
2:50	Projected Need in the Allied Health Professions	Robert Thorpe, Ed.D, RT, *Dept. Of Medical Allied Health Professions, UNC-CH School of Medicine*
3:10	The Role of Integrated Delivery Systems in Setting the Workforce Agenda	W.T. Williams, Jr., MD, *Charlotte-Mecklenburg Hospital Authority*
3:30	Managed Care and Its Effects on the Workforce	William Parham, III, MD, *Member, Blue Cross and Blue Shield of North Carolina*
3:45	Questions and Answers	Members
4:00	Adjourn	

AGENDA

North Carolina Health Care Reform Commission
March 27, 1996

9:00 AM	Welcome and Introductory Remarks	Rep. Zeno L. Edwards, Jr.
9:05	Approval of February 28 Minutes	Members
9:10	Report of Executive Director	James G. Jones, M.D.
9:15	Managed Care in North Carolina Today	Barbara Morales Burke, *Department of Insurance*
10:00	Questions and Answers	Members
10:10	Managed Care—A Panel Discussion	
	• The Industry Perspective	Robert Greczyn, Jr. *Healthsource*
	• The Managed Care Physician Perspective	Robert Bilbro, M.D., *Healthsource*
	• Community Hospital Perspective	Robert E. Morrison, *Pres., Randolph Hospital*
	• The Larger Hospital Network Perspective	Gregory J. Beier, *Executive Vice President, Carolina MediCorps*
	• The Physician Perspective	Sen. James S. Forrester F.M. Mauney, M.D.
11:45	Assessing Quality in Managed Care	Steve Lamb, *The National Committee for Quality Assurance*
12:30 PM	Discussion	Members
12:45	Lunch	
1:45	The Consumers' Concern	
2:00	Helping Consumers Choose an HMO	Jeff Johnston, *Johnston, Zaber and Associates*
2:30	Consideration of Draft Annual Report and Recommendations to the 1996 General Assembly	Rep. Edwards Dr. Jones
4:00	Adjourn	

Appendix B

The Role of the Department of Insurance

WHAT IS THE ROLE OF DEPARTMENT OF INSURANCE?

◊ General and specific information regarding:

Activity/Operational Area	DOI Requirements/Standards for Managed Care Plans
Overall Operations (note: shaded items relate to proposed regulation)	. operates within industry norms and in accordance with company's bylaws . has established policies and procedures and operates in accordance with these . has adequate staffing, structure and information systems . has adequate information systems . documentation maintained appropriately . appropriate integration of functional areas
Health Care Delivery System: . form contracts used (note: shaded items relate to proposed regulation)	. plan must disclose to provider all program & administrative requirements and providers must agree to comply . for HMOs, member may not be billed for excess charges or if the HMO becomes insolvent . provider may not be constrained from sharing info. on treatment options, plan determinations or from assisting in appeal process

WHAT IS THE ROLE OF DEPARTMENT OF INSURANCE? (con'd)

Activity/Operational Area	DOI Requirements/Standards for Managed Care Plans
Network Adequacy & Accessibility (note: shaded items relate to proposed regulation)	. plan has standards to judge adequacy of number & types of providers . plan has standards for accessibility of providers to members, including geographic proximity, wait time for appointments and emergency care . plan evaluates its performance against standards
Verification of Network Providers' Credentials (note: shaded items relate to proposed regulation)	. plan verifies education, training, certifications and references . recredential at least every three years . consideration of information within all departments of the plan (e.g. complaints) during recredentialing
Benefits	. mandated benefits and required provisions included . disclose coverage provisions, including limits and exclusions and requirements for plan members . meaningful product in return for premium

B-2

WHAT IS THE ROLE OF DEPARTMENT OF INSURANCE? (con'd)

Activity/Operational Area	DOI Requirements/Standards for Managed Care Plans
Utilization Review System	. medical policies based on current, clinically valid medical criteria developed with input of providers . systems must be flexible to account for specifics of each case . member appeal process, including expedited appeals, is required . special provisions for emergency situations NOTE: DOI's focus is on system & process, not individual clinical criteria
Member Services: . enrollment & premium billing	. accurate and timely
. member complaints (note: shaded items relate to proposed regulation)	. research and follow-up . fair resolution . feedback into quality assurance program
Quality Management Program (note: shaded items relate to proposed regulation)	. defined quality management program to address clinical and service issues . procedures for identifying and implementing corrective action

B-3

WHAT IS THE ROLE OF DEPARTMENT OF INSURANCE? (con'd)

Activity/Operational Area	DOI Requirements/Standards for Managed Care Plans
Claims Payment	. accurate and timely
Marketing and Advertising	. accurate, complete & not misleading
Premium Rating	. adequate but not excessive . developed within legal requirements . minimum medical loss ratio (HMOs only) 80%
Underwriting	. conducted within legal parameters
Financial Issues	. financially solvent . adequate reserves
Records Retention	. all records maintained for three years or more . available for DOI review
Delegation of Functions to Other Parties (note: shaded items relate to proposed regulation)	. cannot be used to subvert regulation . all standards and requirements apply to contracting party . plan is ultimately responsible for compliance and quality of performance - has obligation to monitor

B-4

WHAT IS THE ROLE OF DEPARTMENT OF INSURANCE? (con'd)

Managed Care & Health Benefits Division

Function:

- ◊ **Licensing of HMOs, registration of PPOs & utilization review companies**
- ◊ **Review of modifications to HMO operations - e.g. service area, change in delivery model. DOI has approval authority.**
- ◊ **Market conduct examinations**
- ◊ **HMO health care provider contracts - DOI has approval authority (not rates or dollar amounts)**
- ◊ **Provider complaints**
- ◊ **Develop policy regarding operations and business practices of managed care companies**

B-5

Managed Care & Health Benefits Division (con'd)

Scope of HMO licensing and examinations:

- ◊ Examination program - blends desktop & on-site review
  - pre-licensure examination - focus is on proposed structure and processes
  - "follow-up" examination - after one year of operations, focus primarily on structure and processes, with some "spot checking" of files, educational approach but still require corrective action plan for violations
  - general examinations - once every three years, by law; looks at structure, process and "outcomes" (sample files), corrective action plan required. (Note: "outcomes" does not mean clinical outcomes.)
  - compliance exam - six to nine months after company accepts report on general examination

Data and Information

- ◊ Examination reports
- ◊ Applications for HMO licensure
- ◊ Form provider contracts
- ◊ Other data collected

Life & Health Division

Function:

- ◊ Review materials given to purchasers of coverage for compliance with laws and regulations regarding benefits, terms of coverage, and marketing/trade activities.
  - master group contracts
  - evidence of coverage
  - advertising materials
- ◊ Develop Departmental policy regarding benefits and products.

R-7

Data & information:

- ◊ Product information/policies
- ◊ Premiums and rating information

Actuarial Services Division

Function:

- ◊ Review and approve premium rate development methods and assumptions. Rates must be adequate but not excessive.
- ◊ Monitor spending patterns.

Financial Evaluation Division

Function:

- ◊ Assess financial solvency of risk-bearing entities
  - review of financial reports made by HMOs and insurance companies
  - analysis of financial reserves
- ◊ Audit financial data and controls through examinations

Data & information:

- ◊ Quarterly and annual financial filings
- ◊ Examination reports

Consumer Services Division

Function:

- ◊ Provide information to consumers regarding rights and obligations of consumers and insurance companies.
- ◊ Respond to/resolve complaints from consumers who have purchased insurance products.

Data & information:

- ◊ Complaint records

LAWS AND REGULATIONS

◊ North Carolina General Statutes (NCGS), Chapter 58
- Article 67 - HMO Act
- Article 50 and 51 - benefit issues, PPOs

◊ North Carolina Administrative Code (NCAC), Title 11
- Chapter 12, Section 0900 - utilization review activities
- Chapter 12, Section 1400 - HMO point-of service
- Chapter 12, in general - relates to benefits and advertising

B-9

◊ Proposed Managed Care Rules (NCAC Title 11, Chapter 12)
- regarding provider contracts, verification of provider credentials, network adequacy and accessibility and quality assurance programs
- focus is on <u>what</u> companies need to do to make sure members get the access to care and quality care that they are promised, without telling them <u>how</u> to accomplish these

MANAGED CARE TRENDS

- ◊ Hybridization of products, dual and triple options
- ◊ Mixed model delivery systems
- ◊ Increased penetration due to gains in commercial market and new markets (such as Medicare, Medicaid and Workers' Compensation)
- ◊ Changes in structure and role of provider entities - larger, more integrated, joint ventures, stakeholders
- ◊ Evolution in provider compensation continues
  - broad-based capitation
  - performance-based incentives (service and medical outcomes, compliance)
  - increasing levels of subcontracting
- ◊ Continued growth, then consolidation
- ◊ Pressure on companies to deliver higher quality, contain costs

B-10

Appendix C

National Committee for Quality Assurance - An Overview

National Committee
for Quality Assurance

2000 L Street, N.W.
Suite 500
Washington, D.C. 20036

Main: 202/955-3500
FAX: 202/955-3599
http://www.ncqa.org

NCQA

NATIONAL COMMITTEE FOR QUALITY ASSURANCE

AN OVERVIEW

What is the National Committee for Quality Assurance?

The National Committee for Quality Assurance (NCQA) is a private, not-for-profit organization dedicated to assessing and reporting on the quality of managed care plans. We are governed by a Board of Directors that includes employers, consumer and labor representatives, health plans, quality experts, regulators, and representatives from organized medicine.

NCQA's mission is to provide information that enables purchasers and consumers of managed health care to distinguish among plans based on quality, thereby allowing them to make more informed decisions. Our efforts are organized around two activities, accreditation and performance measurement, which are complementary strategies for producing information to guide choice. In the future, these activities will be integrated.

Accreditation

NCQA accreditation evaluates **how well a health plan manages** all parts of its delivery system -- both providers (e.g., physicians, hospitals, carve outs) and administrative services -- in order to continuously improve health care for its members. One measure of the value of accreditation is the growing list of employers who are requiring or requesting accreditation of the plans they do business with.

A Sample of Companies Requiring and Requesting NCQA Accreditation Review
Allied Signal
Ameritech
Bristol Myers-Squibb
Chrysler
Digital Equipment
Ford
GE
GTE
IBM
Marriott
Mobil
NationsBank
PepsiCo
Procter & Gamble
UPS
USAir
Xerox

Our accreditation standards represent excellent business practice in six different areas:

- ***Quality Improvement**: Does the plan fully examine the quality of care given to its members? How well does the plan coordinate all parts of its delivery system? What steps does it take to make sure members have access to care in a reasonable amount of time? What improvements in care and service can the plan demonstrate?*

- ***Physician Credentials**: Does the plan meet specific NCQA requirements for investigating the training and experience of all physicians in its network? Does the plan look for any history of malpractice or fraud? Does the plan keep track of all physicians' performance and use that information for their periodic evaluations?*

- ***Members' Rights and Responsibilities**: How clearly does the plan inform members about how to access health services, how to choose a physician or change physicians, and how to make a complaint? How responsive is the plan to members' satisfaction ratings and complaints?*

- ***Preventive Health Services**: Does the plan encourage members to have preventive tests and immunizations? Does the plan support physician efforts to deliver preventive services? Is there evidence of monitoring of the success of preventive care? Is there evidence of improvement, where monitoring suggests an opportunity?*

- ***Utilization Management**: Does the plan use a reasonable and consistent process when deciding what health services are appropriate for individuals' needs? When the plan denies payment for services, does it respond to member and physician appeals? Does the plan protect against under-utilization? Are decisions made by individuals with sufficient expertise to make them?*

- ***Medical Records**: How consistently do the medical records kept by the plan's physicians meet NCQA standards for quality care? For instance, do the records show that physicians follow up on patients' abnormal test findings?*

NCQA reviews are rigorous on-site and off-site evaluations conducted by a team of physicians and managed care experts. A national oversight committee of physicians analyzes the team's findings and assigns an accreditation level based on the Plan's performance compared to NCQA standards. The standards are high -- deliberately so. Accreditation is a rigorous process, and a health plan must be aggressively managing quality to achieve full accreditation. By early 1996, we will have reviewed close to half of the nation's 574 HMOs.

Accreditation Status List

Summary Statistics

January 31, 1996

Decision	Number	Percent
Full	77	36
One-Year	84	39
Provisional	26	12
Denial	28	13
Under Review	1	<1
Total	216	100

Decisions Pending	27	
Initial Reviews Scheduled	90	

Grand Total	333	58 of HMOs

NCQA receives approximately 500 requests per month for its free Accreditation Status List, which lists plans by state or alphabetically by name. Next spring, we will be releasing Accreditation Summary Reports which will provide more detailed information on individual health plan accreditation decisions. The Accreditation Summary Report will illustrate how an individual plan scores against a plan average in each category of standards, thereby showing a plan's strengths and weaknesses.

Performance Measures

Performance measures provide information which is complementary to that of accreditation. Such measures begin to meet purchaser and consumer needs for objective information about health plan performance. Our efforts in this area have focused in four key areas:

- Developing and evolving a **standard performance measurement set** (HEDIS, the Health Plan Employer Data and Information Set);
- Developing an **audit process** to assure that HEDIS data are credible and that production of the measures conform to NCQA specifications;
- Collecting HEDIS measures in a **national database** to make them more accessible to users and to permit benchmarking, comparisons, and other analysis;
- Conducting **consumer research** to assure that future generations of HEDIS will be ever more responsive to consumers' information needs;

HEDIS 2.0, released by NCQA in November 1993, has become the standardized performance measurement system of choice. HEDIS underlies nearly all of the "report cards" individual plans have released in the last year and a half, and currently more than 300 health plans are producing at least some HEDIS statistics.

HEDIS 2.0/2.5 (the latest version is a technical update) includes some 60 standard statistics which focus on clinical quality, access and satisfaction, membership and utilization, and plan financial performance, as well as general plan management information. HEDIS includes

measures of plan performance such as medical loss ratios, immunization rates, and average OB hospital stays.

Over the last couple of years, we have learned much about the strengths and weaknesses of HEDIS through the experiences of employers, plans, and business coalitions that have implemented the measurement set. Specifically, we have tested the feasibility of HEDIS through the Report Card Pilot Project, built a pilot HEDIS database with data from 50 plans, participated in many efforts to produce local market report cards, and clarified HEDIS specifications through NCQA's 126-member HEDIS Users Group. The implementation lessons learned include the following: auditing HEDIS data is critical; benchmarking and analysis are key; and the data collection capabilities of many health plans are limited, but improving.

HEDIS 2.0 was developed by corporate purchasers and health plans to meet their needs, but the desire for such objective information clearly extends beyond the private sector. Earlier this year, we released a draft of HEDIS for Medicaid and the developers of the next generation of HEDIS, HEDIS 3.0, comprise a considerably broader group which includes public purchasers and consumer representatives. This group will set priorities and build consensus around what the future measurement set will include.

Where NCQA is going

On The Accreditation Front

While NCQA's accreditation process, launched in 1991, is relatively mature, we continue to revise our standards to assure currency and to periodically "raise the bar." We are also intent on expanding our accreditation process to evaluate, for example, behavioral managed care. The release of NCQA's Accreditation Summary Reports in June 1996 will likely increase the importance of the review process to purchasers and consumers, as they will have more detailed comparative information on plan performance in individual markets.

With Respect to HEDIS

The Committee on Performance Measurement -- consisting of six public and private purchasers, five health plans, four consumer and labor representatives, and others with necessary knowledge and experience -- has been constituted and charged with managing the evolution of NCQA's performance measurement set. The first product of that group's work --HEDIS 3.0-- will be a more comprehensive information set, for use by both commercial and public purchasers (Medicare and Medicaid), that will likely include a broader range of performance measures, including some outcome measures. Initial funding for HEDIS 3.0 has been secured -- from a foundation, the U.S. Health Care Financing Administration (HCFA) and pharmaceutical companies -- and the measurement set will be ready for implementation testing at the end of 1996. We are confident that it will represent a major step forward in a journey that is far from complete.

Other ongoing NCQA work will be incorporated into HEDIS 3.0 and subsequent HEDIS versions, including a just-released standardized survey of member health care and efforts to develop chronic care measures. NCQA's survey of member health care incorporates the best questions from existing satisfaction surveys in a survey to be fielded by an outside vendor. NCQA's instrument also requires collection of health status data from a random sample of plan members, both to permit adjustment of satisfaction results for differences in population health and to explore the usefulness of health status information to purchasers.

The NCQA National Database

This summer NCQA will make available a National Database of plan-specific HEDIS and accreditation-related information. This central repository of data will address the healthcare community's growing need for access to reliable, standardized quality information. In the future, NCQA hopes to populate this database with HEDIS measures that have been audited.

We are also continuing our research to understand what kind of information consumers find useful – both consumers in private plans and those covered by Medicare and Medicaid. Finally, as NCQA releases more information into the marketplace, we are taking steps to ensure that such information is presented fairly and without bias.

Summary

For the last five years, NCQA has been leading national efforts on behalf of purchasers to develop systems and strategies that create accountability in managed care. Over the next several years we anticipate that our accreditation process will be applied to the vast majority of HMOs so that valuable accreditation information will be available to larger and larger numbers of purchasers and consumers. We will be supporting both local and national efforts to release audited, comparable HEDIS data. And we expect to see an environment in which quality information is available, and health plans are held accountable, thereby fostering discipline and improvement in managed care.

National Committee
for Quality Assurance

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NCQA

February 29, 1996

ACCREDITATION STATUS LIST

Listed Alphabetically

A Fact Sheet

On June 1, 1994, The National Committee for Quality Assurance (NCQA) began regular and full disclosure of health plans' accreditation status to the public. The Accreditation Status List, updated as of the end of each month, catalogs all plans that have an accreditation status with NCQA, all plans with pending accreditation decisions, and all plans scheduled to be reviewed.

What is NCQA accreditation?

It is a nationally recognized evaluation that purchasers, regulators, and consumers can use to assess managed care plans. NCQA accreditation evaluates how well a health plan manages all parts of its delivery system — physicians, hospitals, other providers, and administrative services — in order to continuously improve health care for its members.

NCQA reviews are rigorous on-site and off-site evaluations conducted by a team of physicians and managed care experts. A national oversight committee of physicians analyzes the team's findings and assigns an accreditation level (see page 2) based on the Plan's performance compared to NCQA standards.

These standards — developed by employers, unions, and health plans — are demanding. NCQA has purposely set the standards high to encourage health plans to continuously enhance their quality. No comparable evaluation exists for fee-for-service health care.

What are NCQA's standards?

The 50 standards for quality health plans fall into one of the following six categories:

- ***Quality Improvement:*** Does the Plan fully examine the quality of care given to its members? How well does the Plan coordinate all parts of its delivery system? What steps does it take to make sure members have access to care in a reasonable amount of time? What improvements in care and service can the Plan demonstrate?

- ***Physician Credentials:*** Does the Plan meet specific NCQA requirements for investigating the training and experience of all physicians in its network? Does the Plan look for any history of malpractice or fraud? Does the Plan keep track of all physicians' performance and use that information for their periodic evaluations?

- ***Members' Rights and Responsibilities:*** How clearly does the Plan inform members about how to access health services, how to choose a physician or change physicians, and how to make a complaint? How responsive is the Plan to members' satisfaction ratings and complaints?

- ***Preventive Health Services:*** Does the Plan encourage members to have preventive tests and immunizations? Does the Plan make sure that its physicians are encouraging and delivering preventive services?

- *Utilization Management:* Does the Plan use a reasonable and consistent process when deciding what health services are appropriate for individuals' needs? When the Plan denies payment for services, does it respond to member and physician appeals?

- *Medical Records:* How consistently do the medical records kept by the Plan's physicians meet NCQA standards for quality care? For instance, do the records show that physicians follow up on patients' abnormal test findings?

What is the Accreditation Status List?

The list is in three parts, each organized alphabetically. Part 1 shows all plans that have a current accreditation status; Part 2 shows plans with decisions pending; and Part 3 shows plans with reviews scheduled within the next 18 months. Plans that are not on the list have not scheduled an NCQA accreditation review.

PART 1: Current Accreditation Status. The levels of accreditation decisions are as described briefly below. For a complete description, see the revised NCQA Policies and Procedures. Footnotes indicate plans that have a new decision pending, from a second or third review, or have a new review scheduled.

- *Full Accreditation* is granted for a period of three years to those plans that have excellent programs for continuous quality improvement and meet NCQA's rigorous standards. To date 39 percent of reviewed plans have received Full Accreditation.

- *One-Year Accreditation* is granted to plans that have well-established quality improvement programs and meet most NCQA standards. NCQA provides the plans with a specific list of recommendations, and reviews the plans again after a year to determine if they have progressed enough to move up to Full Accreditation. Currently, 37 percent of plans have received One-Year Accreditation.

- *Provisional Accreditation* is granted for one year to plans that have adequate quality improvement programs and meet some NCQA standards. These plans need to demonstrate progress before they can qualify for higher levels of accreditation. Eleven percent of plans are currently in the Provisional category.

- *Denial* is given to those plans that do not qualify for any of the categories above. Twelve percent of plans reviewed to date have failed to receive accreditation.

- *Under Review* denotes those plans for which an initial accreditation determination has been made but is under review at the request of the plans. Currently, one percent of plans are under review.

PART 2: Initial Decision Pending lists those plans that have been reviewed for the first time but have not yet received a decision.

PART 3: Future Review Scheduled shows the date of all initial reviews scheduled.

How Should Consumers and Purchasers Use the List? Accreditation status is not a guarantee of the quality of care that any individual patient will receive or that any individual physician or other provider delivers. However, plans that are accredited have demonstrated that they provide the consumer protections required by NCQA standards and that they closely monitor, and are continuously improving, the quality of care they deliver.

The National Committee for Quality Assurance, an independent non-profit organization located in Washington, DC, is the nation's leader in improving the quality of care in the managed care industry. NCQA makes health plans accountable for the quality of care and service they deliver in two complementary ways: by evaluating health plans' internal quality processes through accreditation reviews, and by developing measures to gauge health plan performance.

Appendix D

Report on Small Business Insurance

NORTH CAROLINA

SMALL EMPLOYER GROUP

1992 - 1995

ANNUAL ACTIVITY REPORT SUMMARY

NC DEPARTMENT OF INSURANCE
APRIL 1996

1995 Small Group Activity Report Summary
Number of Groups Issued in the 3-25 Market

Row #	COMPANY NAME	BASIC			STANDARD			TRADITIONAL			ALL PLANS			Row #
		YEAR 95	YEAR 95	YEAR 95	YEAR 95	YEAR 95	YEAR 95	YEAR 95	YEAR 95	YEAR 95	YEAR 95	YEAR 95	YEAR 95	
		# NOT PREV INS	# PREV INSURED	# GROUPS ISSUED	# NOT PREV INS	# PREV INSURED	# GROUPS ISSUED	# NOT PREV INS	# PREV INSURED	# GROUPS ISSUED	# NOT PREV INS	# PREV INSURED	# GROUPS ISSUED	
1	AETNA HEALTH PLANS OF THE CAROLINAS, INC	0	0	0	0	0	0	0	0	0	0	0	0	1
2	AETNA LIFE INS CO	0	0	0	0	0	0	0	9	9	0	9	9	2
3	ALLIANZ LIFE INS CO OF NORTH AMERICA	0	0	0	0	0	0	0	3	3	0	3	3	3
4	AMERICAN FIDELITY ASSUR CO	NR	NR	NR	NR	NR	NR	NR	NR	NR	0	0	0	4
5	AMERICAN NATIONAL LIFE INS CO	0	0	0	0	0	0	6	25	31	6	25	31	5
6	AMERICAN SERVICE LIFE INS CO	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	6
7	BANKERS UNITED LIFE ASSUR CO	0	0	0	0	0	0	0	0	0	0	0	0	7
8	BLUE CROSS BLUE SHIELD/NC	0	0	0	25	9	34	441	579	1,020	466	588	1,054	8
9	BOSTON MUTUAL LIFE INS CO	0	0	0	0	0	0	6	9	15	6	9	15	9
10	CELTIC LIFE INS CO	NR	NR	NR	NR	NR	NR	NR	NR	NR	0	0	0	10
11	CENTENNIAL LIFE INS CO	0	0	0	0	0	0	5	22	27	5	22	27	11
12	CENTRAL RESERVE LIFE INS CO	0	0	0	0	0	0	83	72	155	83	72	155	12
13	CIGNA HEALTHCARE OF NORTH CAROLINA	0	0	0	6	30	36	1	21	22	7	51	58	13
14	COLONIAL LIFE INS CO OF AMERICA	0	0	0	0	0	0	UN	UN	4	UN	UN	4	14
15	CONNECTICUT GENERAL LIFE INS CO	0	0	0	0	0	0	0	0	0	0	0	0	15
16	CUNA MUTUAL INSURANCE SOCIETY	0	0	0	0	0	0	UN	UN	2	UN	UN	2	18
17	DOCTORS HEALTH PLAN, INC	0	0	0	0	0	0	UN	UN	4	UN	UN	4	17
18	DURHAM LIFE INS CO	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	18
19	EMPLOYERS HEALTH INS CO	UN	UN	1	UN	UN	16	UN	UN	214	UN	UN	231	19
20	EMPLOYERS LIFE INS CO OF WAUSAU	UN	UN	UN	UN	UN	UN	UN	UN	UN	UN	UN	UN	20
21	FEDERATED MUTUAL INS CO	0	0	0	0	2	2	94	75	169	94	77	171	21
22	FIRST ALLMERICA FINANCIAL LIFE INS CO	0	0	0	0	0	0	0	0	0	0	0	0	22
23	FORTIS BENEFITS INS CO	0	0	0	UN	UN	4	UN	UN	271	UN	UN	275	23
24	FRANKLIN LIFE INS CO	0	0	0	0	2	2	4	6	10	4	8	12	24
25	GENERAL AMERICAN LIFE INS CO	0	0	0	0	0	0	0	0	0	0	0	0	25
26	GREAT-WEST LIFE & ANNUITY INS CO	0	0	0	0	0	0	0	10	10	0	10	10	26
27	GUARDIAN LIFE INS CO	0	0	0	0	0	0	6	18	24	6	18	24	27
28	HEALTHSOURCE, NORTH CAROLINA INC	0	0	0	3	12	15	50	3	53	53	15	68	28
29	HOME LIFE FINANCIAL ASSURANCE CORP	0	0	0	0	3	3	0	30	30	0	33	33	29
30	INDEPENDENT LIFE AND ACCIDENT INS CO	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	30
31	JEFFERSON-PILOT LIFE INS CO	0	0	0	0	0	0	1	12	13	1	12	13	31
32	JOHN ALDEN LIFE INS CO	0	0	0	12	35	47	246	379	625	258	414	672	32
33	JOHN HANCOCK MUTUAL LIFE INS CO	0	0	0	0	0	0	0	0	0	0	0	0	33
34	KAISER FOUNDATION HEALTH PLAN/NC	0	0	0	UN	UN	24	UN	UN	151	UN	UN	175	34
35	KANAWHA INS CO	0	0	0	0	0	0	20	29	49	20	29	49	35
36	LAMAR LIFE INS CO	0	0	0	0	0	0	0	1	1	0	1	1	38
37	LIFE INVESTORS INSURANCE CO OF AMER	0	0	0	0	0	0	0	0	0	0	0	0	37
38	LINCOLN NATIONAL LIFE INS CO	0	0	0	UN	UN	1	UN	UN	58	UN	UN	59	38
39	MAMSI LIFE AND HEALTH INS CO	UN	UN	UN	UN	UN	UN	UN	UN	UN	UN	UN	UN	39
40	MANUFACTURERS LIFE INS CO	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	40
41	MAXICARE NORTH CAROLINA, INC	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	41
42	METRAHEALTH INS CO	0	0	0	0	0	0	0	0	0	0	0	0	42
43	METROPOLITAN LIFE INS CO	0	0	0	0	0	0	0	0	0	0	0	0	43
44	MID-SOUTH INS CO	0	0	0	10	5	15	66	122	188	76	127	203	44
45	MONUMENTAL LIFE INS CO	0	0	0	0	0	0	0	0	0	0	0	0	45

Number of Groups Issued in the 3-25 Market

Row #	COMPANY NAME	BASIC			STANDARD			TRADITIONAL			ALL PLANS			Row #
		YEAR 95	YEAR 95	YEAR 95	YEAR 95	YEAR 95	YEAR 95	YEAR 95	YEAR 95	YEAR 95	YEAR 95	YEAR 95	YEAR 95	
		# NOT PREV INS	# PREV INSURED	# GROUPS ISSUED	# NOT PREV INS	# PREV INSURED	# GROUPS ISSUED	# NOT PREV INS	# PREV INSURED	# GROUPS ISSUED	# NOT PREV INS	# PREV INSURED	# GROUPS ISSUED	
46	NATIONAL AMERICAN LIFE INS CO OF PA	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	46
47	NATIONAL FOUNDATION LIFE INS CO	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	47
48	NATIONAL GROUP LIFE INS CO	UN	UN	1	UN	UN	4	UN	UN	163	UN	UN	168	48
49	NATIONAL HEALTH LIFE INS CO	0	0	0	0	0	0	0	0	0	0	0	0	49
50	NATIONWIDE LIFE INS CO	UN	UN	1	0	0	0	UN	UN	72	UN	UN	73	50
51	NEW ENGLAND MUTUAL LIFE INS CO	0	0	0	2	0	2	114	175	289	116	175	291	51
52	NEW YORK LIFE INS CO	0	0	0	3	2	5	29	36	65	32	38	70	52
53	OPTIMUM CHOICE OF THE CAROLINAS, INC	0	0	0	0	0	0	0	0	0	0	0	0	53
54	PACIFIC MUTUAL LIFE INS CO	0	0	0	0	0	0	10	9	19	10	9	19	54
55	PAN AMERICAN LIFE INS CO	0	0	0	0	0	0	0	0	0	0	0	0	55
56	PARTNERS NATIONAL HEALTH PLAN OF NC	5	25	30	6	40	46	19	64	83	30	129	159	56
57	PFL LIFE INS CO	0	0	0	0	0	0	3	24	27	3	24	27	57
58	PHOENIX AMERICAN LIFE INS CO	0	0	0	0	0	0	0	0	0	0	0	0	58
59	PHOENIX HOME LIFE MUTUAL INS CO	0	0	0	0	0	0	0	0	0	0	0	0	59
60	PHP, INC	UN	UN	1	UN	UN	11	UN	UN	331	UN	UN	343	60
61	PIONEER LIFE INS CO OF ILLINOIS	0	0	0	0	0	0	UN	UN	15	UN	UN	15	61
62	PRINCIPAL HEALTH CARE OF THE CAROLINAS	UN	UN	UN	UN	UN	UN	UN	UN	UN	UN	UN	UN	62
63	PRINCIPAL MUTUAL LIFE INS CO	0	0	0	31	11	42	401	162	563	432	173	605	63
64	PROTECTIVE LIFE INS CO	0	0	0	1	1	2	12	23	35	13	24	37	64
65	PROVIDENT HEALTH CARE PLAN INC OF NC	0	0	0	0	0	0	0	0	0	0	0	0	65
66	PROVIDENT LIFE & ACCIDENT INS CO	0	1	1	2	0	2	53	70	123	55	71	128	66
67	PRUDENTIAL HEALTH CARE PLAN INC	0	1	1	7	4	11	6	17	23	13	22	35	67
68	PRUDENTIAL INS CO OF AMERICA	0	0	0	2	1	3	22	26	48	24	27	51	68
69	SAVERS LIFE INS CO	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	69
70	SECURITY LIFE INS CO OF AMERICA	0	0	0	0	0	0	UN	UN	1	UN	UN	1	70
71	SENTRY LIFE INS CO	0	0	0	0	0	0	6	3	9	6	3	9	71
72	TIME INS CO	0	0	0	0	0	0	6	24	30	6	24	30	72
73	TMG LIFE INS CO	0	0	0	1	3	4	22	190	212	23	193	216	73
74	TRAVELERS INS CO	0	0	0	9	16	25	80	347	427	89	363	452	74
75	TRUSTMARK INSURANCE CO	0	0	0	6	3	9	77	247	324	83	250	333	75
76	UNITED OF OMAHA INS CO	0	0	0	4	1	5	71	72	143	75	73	148	76
77	UNITED STATES LIFE INS CO	0	0	0	0	0	0	0	0	0	0	0	0	77
78	UNITED WISCONSIN LIFE INS CO	0	0	0	0	2	2	0	199	199	0	201	201	78
79	UNITED WORLD LIFE INS CO	0	0	0	0	0	0	13	13	26	13	13	28	79
80	US HEALTHCARE OF THE CAROLINAS INC	0	0	0	0	0	0	0	0	0	0	0	0	80
81	WELLPATH COMMUNITY HEALTH PLANS INC	0	0	0	0	0	0	0	0	0	0	0	0	81
82	WESTERN FIDELITY INS CO	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	82
	TOTAL	5	27	36	130	182	372	1,973	3,126	6,385	2,108	3,335	6,793	

COLUMN AND ROW TOTALS MAY NOT ADD CORRECTLY DUE TO SOME CARRIERS' INABILITY TO PROVIDE THE DATA IN THE DETAIL REQUIRED

UN = UNKNOWN

N/A = NOT APPLICABLE

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COMPANY NAME IN BOLD INDICATES A RISK ASSUMING CARRIER

NATIONWIDE LIFE INS CO INCLUDES EMPLOYERS LIFE INS CO OF WAUSAU

FIRST ALLMERICA FINANCIAL LIFE INS CO WAS FORMERLY STATE MUTUAL LIFE ASSUR CO OF AMERICA

1995 Small Group Activity Report Summary
Number of Groups Issued in the One-Man/Self-Employed Market

Row #	COMPANY NAME	BASIC			STANDARD			TRADITIONAL			ALL PLANS			Row #
		YEAR 95	YEAR 95	YEAR 95	YEAR 95	YEAR 95	YEAR 95	YEAR 95	YEAR 95	YEAR 95	YEAR 95	YEAR 95	YEAR 95	
		# NOT PREV INS	# PREV INSURED	# GROUPS ISSUED	# NOT PREV INS	# PREV INSURED	# GROUPS ISSUED	# NOT PREV INS	# PREV INSURED	# GROUPS ISSUED	# NOT PREV INS	# PREV INSURED	# GROUPS ISSUED	
1	AETNA HEALTH PLANS OF THE CAROLINAS, INC	0	0	0	0	0	0	0	0	0	0	0	0	1
2	AETNA LIFE INS CO	0	0	0	0	0	0	0	0	0	0	0	0	2
3	ALLIANZ LIFE INS CO OF NORTH AMERICA	0	0	0	0	0	0	0	0	0	0	0	0	3
4	AMERICAN FIDELITY ASSUR CO	NR	NR	NR	NR	NR	NR	NR	NR	NR	0	0	0	4
5	AMERICAN NATIONAL LIFE INS CO	0	0	0	0	0	0	0	0	0	0	0	0	5
6	AMERICAN SERVICE LIFE INS CO	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	8
7	BANKERS UNITED LIFE ASSUR CO	0	0	0	0	0	0	0	0	0	0	0	0	7
8	BLUE CROSS BLUE SHIELD/NC	1	0	1	47	5	52	433	106	539	481	111	592	8
9	BOSTON MUTUAL LIFE INS CO	0	0	0	0	0	0	1	0	1	1	0	1	9
10	CELTIC LIFE INS CO	NR	NR	NR	NR	NR	NR	NR	NR	NR	0	0	0	10
11	CENTENNIAL LIFE INS CO	0	0	0	0	0	0	0	17	17	0	17	17	11
12	CENTRAL RESERVE LIFE INS CO	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CIGNA HEALTHCARE OF NORTH CAROLINA	0	1	1	100	18	118	0	0	0	100	19	119	13
14	COLONIAL LIFE INS CO OF AMERICA	0	0	0	0	0	0	0	0	0	0	0	0	14
15	CONNECTICUT GENERAL LIFE INS CO	0	0	0	0	0	0	0	0	0	0	0	0	15
18	CUNA MUTUAL INSURANCE SOCIETY	0	0	0	0	0	0	0	0	0	0	0	0	18
17	DOCTORS HEALTH PLAN, INC	0	0	0	UN	UN	1	UN	UN	10	UN	UN	11	17
18	DURHAM LIFE INS CO	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	18
19	EMPLOYERS HEALTH INS CO	0	0	0	0	0	0	0	0	0	0	0	0	19
20	EMPLOYERS LIFE INS CO OF WAUSAU	UN	UN	UN	UN	UN	UN	UN	UN	UN	UN	UN	UN	20
21	FEDERATED MUTUAL INS CO	0	0	0	0	0	0	0	0	0	0	0	0	21
22	FIRST ALLMERICA FINANCIAL LIFE INS CO	0	0	0	0	0	0	0	0	0	0	0	0	22
23	FORTIS BENEFITS INS CO	0	0	0	0	0	0	UN	UN	36	UN	UN	38	23
24	FRANKLIN LIFE INS CO	1	0	1	2	0	2	1	0	1	4	0	4	24
25	GENERAL AMERICAN LIFE INS CO	0	0	0	0	0	0	0	0	0	0	0	0	25
26	GREAT-WEST LIFE & ANNUITY INS CO	0	0	0	0	0	0	0	0	0	0	0	0	28
27	GUARDIAN LIFE INS CO	0	0	0	0	0	0	4	0	4	4	0	4	27
28	HEALTHSOURCE, NORTH CAROLINA INC	2	0	2	4	9	13	7	36	43	13	45	58	28
29	HOME LIFE FINANCIAL ASSURANCE CORP	0	0	0	0	2	2	0	12	12	0	14	14	29
30	INDEPENDENT LIFE AND ACCIDENT INS CO	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	30
31	JEFFERSON-PILOT LIFE INS CO	0	0	0	0	0	0	0	0	0	0	0	0	31
32	JOHN ALDEN LIFE INS CO	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR	32
33	JOHN HANCOCK MUTUAL LIFE INS CO	0	0	0	0	0	0	0	0	0	0	0	0	33
34	KAISER FOUNDATION HEALTH PLAN/NC	UN	UN	4	UN	UN	175	UN	UN	8	UN	UN	185	34
35	KANAWHA INS CO	0	0	0	1	0	1	3	13	16	4	13	17	35
38	LAMAR LIFE INS CO	0	0	0	0	0	0	0	0	0	0	0	0	38
37	LIFE INVESTORS INSURANCE CO OF AMER	0	0	0	0	0	0	0	0	0	0	0	0	37
38	LINCOLN NATIONAL LIFE INS CO	0	0	0	0	0	0	0	0	0	0	0	0	38
39	MAMSI LIFE AND HEALTH INS CO	UN	UN	UN	UN	UN	UN	UN	UN	UN	UN	UN	UN	39
40	MANUFACTURERS LIFE INS CO	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	40
41	MAXICARE NORTH CAROLINA, INC	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	41
42	METRAHEALTH INS CO	0	0	0	0	0	0	0	0	0	0	0	0	42
43	METROPOLITAN LIFE INS CO	0	0	0	0	0	0	0	0	0	0	0	0	43
44	MID-SOUTH INS CO	1	1	2	23	9	32	23	8	31	47	18	65	44
45	MONUMENTAL LIFE INS CO	0	0	0	0	0	0	3	0	3	3	0	3	45

Number of Groups Issued in the One-Man/Self-Employed Market

Row #	COMPANY NAME	BASIC YEAR 95 # NOT PREV INS	BASIC YEAR 95 # PREV INSURED	BASIC YEAR 95 # GROUPS ISSUED	STANDARD YEAR 95 # NOT PREV INS	STANDARD YEAR 95 # PREV INSURED	STANDARD YEAR 95 # GROUPS ISSUED	TRADITIONAL YEAR 95 # NOT PREV INS	TRADITIONAL YEAR 95 # PREV INSURED	TRADITIONAL YEAR 95 # GROUPS ISSUED	ALL PLANS YEAR 95 # NOT PREV INS	ALL PLANS YEAR 95 # PREV INSURED	ALL PLANS YEAR 95 # GROUPS ISSUED	Row #
46	NATIONAL AMERICAN LIFE INS CO OF PA	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	46
47	NATIONAL FOUNDATION LIFE INS CO	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	47
48	NATIONAL GROUP LIFE INS CO	0	0	0	0	0	0	UN	UN	24	UN	UN	24	48
49	NATIONAL HEALTH LIFE INS CO	0	0	0	0	0	0	0	0	0	0	0	0	49
50	NATIONWIDE LIFE INS CO	UN	UN	1	0	0	0	0	0	0	UN	UN	1	50
51	NEW ENGLAND MUTUAL LIFE INS CO	0	0	0	1	0	1	52	24	78	53	24	77	51
52	NEW YORK LIFE INS CO	0	0	0	11	2	13	33	21	54	44	23	67	52
53	OPTIMUM CHOICE OF THE CAROLINAS, INC	0	0	0	0	0	0	0	0	0	0	0	0	53
54	PACIFIC MUTUAL LIFE INS CO	0	0	0	0	0	0	7	4	11	7	4	11	54
55	PAN AMERICAN LIFE INS CO	0	0	0	0	0	0	1	0	1	1	0	1	55
56	PARTNERS NATIONAL HEALTH PLAN OF NC	3	5	8	3	6	9	3	3	6	9	14	23	56
57	PFL LIFE INS CO	3	13	16	4	27	31	551	2,530	3,081	558	2,570	3,128	57
58	PHOENIX AMERICAN LIFE INS CO	0	0	0	0	0	0	0	0	0	0	0	0	58
59	PHOENIX HOME LIFE MUTUAL INS CO	0	0	0	0	0	0	0	0	0	0	0	0	59
60	PHP, INC	UN	UN	1	UN	UN	8	UN	UN	172	UN	UN	181	60
61	PIONEER LIFE INS CO OF ILLINOIS	0	0	0	0	0	0	UN	UN	2	UN	UN	2	61
62	PRINCIPAL HEALTH CARE OF THE CAROLINAS	UN	UN	UN	UN	UN	UN	UN	UN	UN	UN	UN	UN	82
63	PRINCIPAL MUTUAL LIFE INS CO	0	0	0	63	9	72	205	38	243	288	47	315	63
64	PROTECTIVE LIFE INS CO	0	0	0	2	4	6	19	37	56	21	41	62	64
65	PROVIDENT HEALTH CARE PLAN INC OF NC	0	0	0	0	0	0	0	0	0	0	0	0	65
66	PROVIDENT LIFE & ACCIDENT INS CO	0	0	0	11	7	18	64	37	101	75	44	119	68
67	PRUDENTIAL HEALTH CARE PLAN INC	4	0	4	7	3	10	24	8	30	35	9	44	87
68	PRUDENTIAL INS CO OF AMERICA	0	0	0	7	2	9	20	6	28	27	8	35	68
69	SAVERS LIFE INS CO	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	69
70	SECURITY LIFE INS CO OF AMERICA	0	0	0	0	0	0	UN	UN	24	UN	UN	24	70
71	SENTRY LIFE INS CO	0	0	0	0	0	0	2	0	2	2	0	2	71
72	TIME INS CO	0	0	0	0	4	4	6	5	11	8	9	15	72
73	TMG LIFE INS CO	0	0	0	0	2	2	15	52	67	15	54	89	73
74	TRAVELERS INS CO	0	0	0	0	0	0	0	0	0	0	0	0	74
75	TRUSTMARK INSURANCE CO	0	0	0	9	2	11	181	62	243	190	64	254	75
78	UNITED OF OMAHA INS CO	1	0	1	10	2	12	151	44	195	162	46	208	78
77	UNITED STATES LIFE INS CO	0	0	0	0	0	0	0	0	0	0	0	0	77
78	UNITED WISCONSIN LIFE INS CO	0	1	1	0	8	8	0	1,150	1,150	0	1,159	1,159	78
79	UNITED WORLD LIFE INS CO	0	1	1	1	9	10	4	24	28	5	34	39	79
80	US HEALTHCARE OF THE CAROLINAS INC	0	0	0	0	0	0	0	0	0	0	0	0	80
81	WELLPATH COMMUNITY HEALTH PLANS INC	0	0	0	0	0	0	0	0	0	0	0	0	81
82	WESTERN FIDELITY INS CO	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	82
	TOTAL	16	22	44	306	130	620	1,813	4,235	6,322	2,135	4,387	8,986	

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NATIONWIDE LIFE INS CO INCLUDES EMPLOYERS LIFE INS CO OF WAUSAU

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1995 Small Group Activity Report Summary
Number of Groups Issued in the 1-49 Market

Row #	COMPANY NAME	BASIC			STANDARD			TRADITIONAL			ALL PLANS			Row #
		YEAR 95	YEAR 95	YEAR 95	YEAR 95	YEAR 95	YEAR 95	YEAR 95	YEAR 95	YEAR 95	YEAR 95	YEAR 95	YEAR 95	
		# NOT PREV INS	# PREV INSURED	# GROUPS ISSUED	# NOT PREV INS	# PREV INSURED	# GROUPS ISSUED	# NOT PREV INS	# PREV INSURED	# GROUPS ISSUED	# NOT PREV INS	# PREV INSURED	# GROUPS ISSUED	
1	AETNA HEALTH PLANS OF THE CAROLINAS, INC	0	0	0	0	0	0	0	1	1	0	1	1	1
2	AETNA LIFE INS CO	0	0	0	0	0	0	0	19	19	0	19	19	2
3	ALLIANZ LIFE INS CO OF NORTH AMERICA	0	0	0	0	0	0	0	4	4	0	4	4	3
4	AMERICAN FIDELITY ASSUR CO	NR	NR	NR	NR	NR	NR	NR	NR	NR	0	0	0	4
5	AMERICAN NATIONAL LIFE INS CO	0	0	0	0	0	0	20	31	51	20	31	51	5
6	AMERICAN SERVICE LIFE INS CO	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	8
7	BANKERS UNITED LIFE ASSUR CO	0	0	0	0	0	0	0	0	0	0	0	0	7
8	BLUE CROSS BLUE SHIELD/NC	1	0	1	82	24	106	1,081	872	1,953	1,184	898	2,060	8
9	BOSTON MUTUAL LIFE INS CO	0	0	0	1	0	1	67	37	104	68	37	105	9
10	CELTIC LIFE INS CO	NR	NR	NR	NR	NR	NR	NR	NR	NR	0	0	0	10
11	CENTENNIAL LIFE INS CO	0	0	0	0	0	0	7	59	66	7	59	66	11
12	CENTRAL RESERVE LIFE INS CO	0	0	0	4	3	7	149	106	255	153	109	262	12
13	CIGNA HEALTHCARE OF NORTH CAROLINA	0	1	1	106	50	156	1	29	30	107	80	187	13
14	COLONIAL LIFE INS CO OF AMERICA	0	0	0	0	0	0	UN	UN	4	UN	UN	4	14
15	CONNECTICUT GENERAL LIFE INS CO	0	0	0	0	0	0	0	0	0	0	0	0	15
16	CUNA MUTUAL INSURANCE SOCIETY	0	0	0	0	0	0	UN	UN	4	0	0	4	18
17	DOCTORS HEALTH PLAN, INC	0	0	0	UN	UN	2	UN	UN	15	UN	UN	17	17
18	DURHAM LIFE INS CO	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	18
19	EMPLOYERS HEALTH INS CO	UN	UN	1	UN	UN	43	UN	UN	445	UN	UN	489	19
20	EMPLOYERS LIFE INS CO OF WAUSAU	UN	UN	UN	UN	UN	UN	UN	UN	UN	UN	UN	UN	20
21	FEDERATED MUTUAL INS CO	0	0	0	0	2	2	121	88	209	121	90	211	21
22	FIRST ALLMERICA FINANCIAL LIFE INS CO	0	0	0	0	0	0	0	0	0	0	0	0	22
23	FORTIS BENEFITS INS CO	0	0	0	UN	UN	4	UN	UN	329	UN	UN	333	23
24	FRANKLIN LIFE INS CO	1	0	1	2	3	5	5	8	13	8	11	19	24
25	GENERAL AMERICAN LIFE INS CO	0	0	0	0	1	1	0	0	0	0	1	1	25
26	GREAT-WEST LIFE & ANNUITY INS CO	0	0	0	0	0	0	0	35	35	0	35	35	28
27	GUARDIAN LIFE INS CO	0	0	0	2	1	3	11	26	37	13	27	40	27
28	HEALTHSOURCE; NORTH CAROLINA INC	2	0	2	9	33	42	21	131	152	32	164	198	28
29	HOME LIFE FINANCIAL ASSURANCE CORP	0	0	0	0	6	6	0	48	48	0	54	54	29
30	INDEPENDENT LIFE AND ACCIDENT INS CO	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	30
31	JEFFERSON-PILOT LIFE INS CO	0	0	0	0	0	0	1	45	46	1	45	48	31
32	JOHN ALDEN LIFE INS CO	0	0	0	30	53	83	482	579	1,061	512	632	1,144	32
33	JOHN HANCOCK MUTUAL LIFE INS CO	0	0	0	0	0	0	0	0	0	0	0	0	33
34	KAISER FOUNDATION HEALTH PLAN/NC	UN	UN	4	UN	UN	199	UN	UN	165	UN	UN	388	34
35	KANAWHA INS CO	0	0	0	1	1	2	23	51	74	24	52	78	35
36	LAMAR LIFE INS CO	0	0	0	0	0	0	0	1	1	0	1	1	38
37	LIFE INVESTORS INSURANCE CO OF AMER	0	0	0	0	0	0	0	0	0	0	0	0	37
38	LINCOLN NATIONAL LIFE INS CO	UN	UN	1	UN	UN	7	UN	UN	124	UN	UN	132	38
39	MAMSI LIFE AND HEALTH INS CO	0	0	0	1	2	3	148	442	590	149	444	593	39
40	MANUFACTURERS LIFE INS CO	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	40
41	MAXICARE NORTH CAROLINA, INC	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	41
42	METRAHEALTH INS CO	0	0	0	0	0	0	0	0	0	0	0	0	42
43	METROPOLITAN LIFE INS CO	0	0	0	0	0	0	0	0	0	0	0	0	43
44	MID-SOUTH INS CO	1	1	2	37	14	51	102	144	246	140	159	299	44
45	MONUMENTAL LIFE INS CO	0	0	0	0	0	0	3	0	3	3	0	3	45

Number of Groups Issued in the 1-49 Market

Row #	COMPANY NAME	BASIC YEAR 95 # NOT PREV INS	BASIC YEAR 95 # PREV INSURED	BASIC YEAR 95 # GROUPS ISSUED	STANDARD YEAR 95 # NOT PREV INS	STANDARD YEAR 95 # PREV INSURED	STANDARD YEAR 95 # GROUPS ISSUED	TRADITIONAL YEAR 95 # NOT PREV INS	TRADITIONAL YEAR 95 # PREV INSURED	TRADITIONAL YEAR 95 # GROUPS ISSUED	ALL PLANS YEAR 95 # NOT PREV INS	ALL PLANS YEAR 95 # PREV INSURED	ALL PLANS YEAR 95 # GROUPS ISSUED	Row #
46	NATIONAL AMERICAN LIFE INS CO OF PA	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	48
47	NATIONAL FOUNDATION LIFE INS CO	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	47
48	NATIONAL GROUP LIFE INS CO	UN	UN	1	UN	UN	5	UN	UN	344	UN	UN	350	48
49	NATIONAL HEALTH LIFE INS CO	0	0	0	0	0	0	0	0	0	0	0	0	49
50	NATIONWIDE LIFE INS CO	UN	UN	3	0	0	0	UN	UN	112	UN	UN	115	50
51	NEW ENGLAND MUTUAL LIFE INS CO	0	0	0	3	0	3	220	244	484	223	244	487	51
52	NEW YORK LIFE INS CO	0	0	0	14	4	18	62	57	119	78	81	137	52
53	OPTIMUM CHOICE OF THE CAROLINAS, INC	0	0	0	0	0	0	0	0	0	0	0	0	53
54	PACIFIC MUTUAL LIFE INS CO	0	0	0	0	0	0	18	13	31	18	13	31	54
55	PAN AMERICAN LIFE INS CO	0	0	0	0	0	0	1	0	1	1	0	1	55
56	PARTNERS NATIONAL HEALTH PLAN OF NC	17	41	58	34	49	83	21	126	147	72	216	288	58
57	PFL LIFE INS CO	3	13	18	4	28	32	572	2,631	3,203	579	2,672	3,251	57
58	PHOENIX AMERICAN LIFE INS CO	0	0	0	0	0	0	0	0	0	0	0	0	58
59	PHOENIX HOME LIFE MUTUAL INS CO	0	0	0	0	0	0	0	0	0	0	0	0	59
60	PHP, INC	UN	UN	2	UN	UN	21	UN	UN	829	UN	UN	652	80
61	PIONEER LIFE INS CO OF ILLINOIS	0	0	0	0	0	0	UN	UN	21	UN	UN	21	81
62	PRINCIPAL HEALTH CARE OF THE CAROLINAS	0	1	1	0	6	6	0	0	0	0	7	7	82
63	PRINCIPAL MUTUAL LIFE INS CO	0	0	0	118	23	141	836	239	1,075	954	282	1,218	83
64	PROTECTIVE LIFE INS CO	0	0	0	3	6	9	38	75	113	41	81	122	84
65	PROVIDENT HEALTH CARE PLAN INC OF NC	0	0	0	0	0	0	0	0	0	0	0	0	85
66	PROVIDENT LIFE & ACCIDENT INS CO	0	1	1	22	10	32	165	148	313	187	159	346	66
67	PRUDENTIAL HEALTH CARE PLAN INC	4	1	5	24	8	32	46	29	75	74	38	112	87
68	PRUDENTIAL INS CO OF AMERICA	0	0	0	3	11	14	62	41	103	65	52	117	88
69	SAVERS LIFE INS CO	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	69
70	SECURITY LIFE INS CO OF AMERICA	0	0	0	0	0	0	UN	UN	1	UN	UN	1	70
71	SENTRY LIFE INS CO	0	0	0	0	0	0	12	3	15	12	3	15	71
72	TIME INS CO	0	0	0	1	5	6	31	42	73	32	47	79	72
73	TMG LIFE INS CO	0	0	0	8	13	21	219	2,378	2,595	227	2,389	2,618	73
74	TRAVELERS INS CO	2	0	2	30	12	42	182	563	745	214	575	789	74
75	TRUSTMARK INSURANCE CO	0	0	0	20	6	26	369	394	763	389	400	789	75
76	UNITED OF OMAHA INS CO	1	0	1	16	4	20	278	141	419	295	145	440	78
77	UNITED STATES LIFE INS CO	0	0	0	0	0	0	0	0	0	0	0	0	77
78	UNITED WISCONSIN LIFE INS CO	0	1	1	0	14	14	0	1,613	1,613	0	1,828	1,628	78
79	UNITED WORLD LIFE INS CO	0	1	1	2	9	11	18	41	59	20	51	71	79
80	US HEALTHCARE OF THE CAROLINAS INC	0	0	0	0	0	0	0	0	0	0	0	0	80
81	WELLPATH COMMUNITY HEALTH PLANS INC	0	0	0	0	0	0	0	0	0	0	0	0	81
82	WESTERN FIDELITY INS CO	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	82
	TOTAL	32	61	105	577	401	1,259	5,392	11,532	19,117	6,001	11,994	20,481	

COLUMN AND ROW TOTALS MAY NOT ADD CORRECTLY DUE TO SOME CARRIERS' INABILITY TO PROVIDE THE DATA IN THE DETAIL REQUIRED

UN = UNKNOWN

N/A = NOT APPLICABLE

NR = NOT REPORTED

COMPANY NAME IN BOLD INDICATES A RISK ASSUMING CARRIER

NATIONWIDE LIFE INS CO INCLUDES EMPLOYERS LIFE INS CO OF WAUSAU

FIRST ALLMERICA FINANCIAL LIFE INS CO WAS FORMERLY STATE MUTUAL LIFE ASSUR CO OF AMERICA

1995 Small Group Activity Report Summary
Total Inforce In 3-25 Market as of 12/31/95

Exhibit 8

Row #	COMPANY NAME	# OF GROUPS INFORCE YEAR 95 BASIC	YEAR 95 STD	YEAR 95 TRAD	YEAR 95 ALL PLANS	# OF EMPLOYEES COVERED YEAR 95 BASIC	YEAR 95 STD	YEAR 95 TRAD	YEAR 95 ALL PLANS	AVERAGE GROUP SIZE ALL PLANS	Row #
1	AETNA HEALTH PLANS OF THE CAROLINAS, INC	0	0	0	0	0	0	0	0	0.0	1
2	AETNA LIFE INS CO	0	0	67	67	0	0	963	963	14.4	2
3	ALLIANZ LIFE INS CO OF NORTH AMERICA	0	0	3	3	0	0	7	7	2.3	3
4	AMERICAN FIDELITY ASSUR CO	NR	NR	NR	NR	NR	NR	NR	NR	NR	4
5	AMERICAN NATIONAL LIFE INS CO	0	0	34	34	0	0	256	258	7.5	5
6	AMERICAN SERVICE LIFE INS CO	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	8
7	BANKERS UNITED LIFE ASSUR CO	0	0	1	1	0	0	7	7	7.0	7
8	BLUE CROSS BLUE SHIELD/NC	0	121	7,343	7,464	0	646	57,396	58,042	7.8	8
9	BOSTON MUTUAL LIFE INS CO	0	0	15	15	0	0	99	99	6.8	9
10	CELTIC LIFE INS CO	NR	NR	NR	NR	NR	NR	NR	NR	NR	10
11	CENTENNIAL LIFE INS CO	0	0	85	85	0	0	593	593	7.0	11
12	CENTRAL RESERVE LIFE INS CO	0	1	477	478	0	3	3,014	3,017	8.3	12
13	CIGNA HEALTHCARE OF NORTH CAROLINA	0	53	31	84	0	328	478	806	9.8	13
14	COLONIAL LIFE INS CO OF AMERICA	0	0	19	19	0	0	260	260	13.7	14
15	CONNECTICUT GENERAL LIFE INS CO	0	0	4	4	0	0	38	38	9.5	15
16	CUNA MUTUAL INSURANCE SOCIETY	0	0	48	48	0	0	409	409	8.5	16
17	DOCTORS HEALTH PLAN, INC	0	0	4	4	0	0	19	19	4.8	17
18	DURHAM LIFE INS CO	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	18
19	EMPLOYERS HEALTH INS CO	1	23	678	702	3	108	4,551	4,662	6.6	19
20	EMPLOYERS LIFE INS CO OF WAUSAU	UN	UN	UN	UN	UN	UN	UN	UN	UN	20
21	FEDERATED MUTUAL INS CO	0	2	169	171	0	13	1,075	1,088	6.4	21
22	FIRST ALLMERICA FINANCIAL LIFE INS CO	0	0	0	0	0	0	0	0	0.0	22
23	FORTIS BENEFITS INS CO	0	4	555	559	0	27	4,449	4,476	8.0	23
24	FRANKLIN LIFE INS CO	0	2	23	25	0	14	148	162	6.5	24
25	GENERAL AMERICAN LIFE INS CO	0	7	16	23	0	86	104	190	8.3	25
26	GREAT-WEST LIFE & ANNUITY INS CO	0	0	10	10	0	0	235	235	23.5	26
27	GUARDIAN LIFE INS CO	0	1	556	557	0	5	4,859	4,864	8.7	27
28	HEALTHSOURCE, NORTH CAROLINA INC	0	15	53	68	0	98	355	453	6.7	28
29	HOME LIFE FINANCIAL ASSURANCE CORP	0	5	155	160	0	30	1,006	1,036	6.5	29
30	INDEPENDENT LIFE AND ACCIDENT INS CO	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	30
31	JEFFERSON-PILOT LIFE INS CO	0	0	89	89	0	0	1,416	1,416	15.9	31
32	JOHN ALDEN LIFE INS CO	0	71	3,636	3,707	0	347	22,415	22,762	6.1	32
33	JOHN HANCOCK MUTUAL LIFE INS CO	0	0	100	100	0	0	626	626	6.3	33
34	KAISER FOUNDATION HEALTH PLAN/NC	0	28	530	558	0	60	2,983	3,043	5.5	34
35	KANAWHA INS CO	0	1	105	106	0	4	792	796	7.5	35
36	LAMAR LIFE INS CO	0	0	4	4	0	0	29	29	7.3	38
37	LIFE INVESTORS INSURANCE CO OF AMER	0	0	5	5	0	0	18	18	3.6	37
38	LINCOLN NATIONAL LIFE INS CO	0	5	231	236	0	21	1,182	1,203	5.1	38
39	MAMSI LIFE AND HEALTH INS CO	UN	UN	UN	UN	UN	UN	UN	UN	UN	39
40	MANUFACTURERS LIFE INS CO	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	40
41	MAXICARE NORTH CAROLINA, INC	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	41
42	METRAHEALTH INS CO	0	0	0	0	0	0	0	0	0.0	42
43	METROPOLITAN LIFE INS CO	0	1	36	37	0	10	201	211	5.7	43
44	MID-SOUTH INS CO	0	11	664	675	0	51	5,592	5,643	8.4	44
45	MONUMENTAL LIFE INS CO	0	0	101	101	0	0	467	467	4.6	45

1995 Small Group Activity Report Summary
Total Inforce In 3-25 Market as of 12/31/95

Row #	COMPANY NAME	# OF GROUPS INFORCE YEAR 95 BASIC	YEAR 95 STD	YEAR 95 TRAD	YEAR 95 ALL PLANS	# OF EMPLOYEES COVERED YEAR 95 BASIC	YEAR 95 STD	YEAR 95 TRAD	YEAR 95 ALL PLANS	AVERAGE GROUP SIZE ALL PLANS	Row #
46	NATIONAL AMERICAN LIFE INS CO OF PA	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	48
47	NATIONAL FOUNDATION LIFE INS CO	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	47
48	NATIONAL GROUP LIFE INS CO	1	4	301	306	3	20	1,263	1,286	4.2	48
49	NATIONAL HEALTH LIFE INS CO	0	0	6	6	0	0	18	18	3.0	49
50	NATIONWIDE LIFE INS CO	4	0	377	381	14	0	2,517	2,631	8.8	50
51	NEW ENGLAND MUTUAL LIFE INS CO	0	2	268	270	0	7	1,803	1,810	6.7	61
52	NEW YORK LIFE INS CO	0	15	326	341	0	62	1,966	2,028	5.9	62
53	OPTIMUM CHOICE OF THE CAROLINAS, INC	0	0	0	0	0	0	0	0	0.0	53
54	PACIFIC MUTUAL LIFE INS CO	0	0	66	66	0	0	573	573	8.7	54
55	PAN AMERICAN LIFE INS CO	0	6	150	155	0	25	770	795	6.1	55
56	PARTNERS NATIONAL HEALTH PLAN OF NC	30	46	83	159	155	324	844	1,323	8.3	56
57	PFL LIFE INS CO	0	0	36	36	0	0	122	122	3.4	57
58	PHOENIX AMERICAN LIFE INS CO	0	0	1	1	0	0	24	24	24.0	58
59	PHOENIX HOME LIFE MUTUAL INS CO	0	0	7	7	0	0	76	76	10.9	59
60	PHP, INC	1	12	718	731	5	59	4,778	4,842	6.6	60
61	PIONEER LIFE INS CO OF ILLINOIS	0	2	101	103	0	8	521	529	5.1	61
62	PRINCIPAL HEALTH CARE OF THE CAROLINAS	UN	UN	UN	UN	UN	UN	UN	UN	UN	62
63	PRINCIPAL MUTUAL LIFE INS CO	1	104	4,244	4,349	3	656	31,954	32,613	7.5	63
64	PROTECTIVE LIFE INS CO	0	10	183	193	0	44	991	1,035	6.4	64
65	PROVIDENT HEALTH CARE PLAN INC OF NC	0	0	0	0	0	0	0	0	0.0	65
66	PROVIDENT LIFE & ACCIDENT INS CO	0	5	165	170	0	26	1,203	1,229	7.2	66
67	PRUDENTIAL HEALTH CARE PLAN INC	1	11	27	39	11	73	183	267	6.8	67
68	PRUDENTIAL INS CO OF AMERICA	0	2	495	497	0	11	3,094	3,105	6.2	68
69	SAVERS LIFE INS CO	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	69
70	SECURITY LIFE INS CO OF AMERICA	0	0	5	5	0	0	40	40	8.0	70
71	SENTRY LIFE INS CO	0	0	29	29	0	0	160	160	5.5	71
72	TIME INS CO	0	1	238	239	0	3	958	961	4.0	72
73	TMG LIFE INS CO	0	6	578	584	0	26	4,377	4,403	7.5	73
74	TRAVELERS INS CO	0	24	1,617	1,641	0	205	12,055	12,260	7.5	74
75	TRUSTMARK INSURANCE CO	0	14	504	518	0	120	4,781	4,901	9.5	75
76	UNITED OF OMAHA INS CO	0	7	366	373	0	28	2,151	2,179	5.8	76
77	UNITED STATES LIFE INS CO	0	0	7	7	0	0	43	43	6.1	77
78	UNITED WISCONSIN LIFE INS CO	0	2	199	201	0	6	1,106	1,112	5.5	78
79	UNITED WORLD LIFE INS CO	0	0	33	33	0	0	181	181	5.5	79
80	US HEALTHCARE OF THE CAROLINAS INC	0	0	0	0	0	0	0	0	0.0	80
81	WELLPATH COMMUNITY HEALTH PLANS INC	0	0	0	0	0	0	0	0	0.0	81
82	WESTERN FIDELITY INS CO	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	82
	TOTAL	39	623	26,977	27,639	194	3,554	194,594	198,342	7.2	

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UN = UNKNOWN
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COMPANY NAME IN BOLD INDICATES A RISK ASSUMING CARRIER

NATIONWIDE LIFE INS CO INCLUDES EMPLOYERS LIFE INS CO OF WAUSAU
FIRST ALLMERICA FINANCIAL LIFE INS CO WAS FORMERLY STATE MUTUAL LIFE ASSUR CO OF AMERICA

1995 Small Group Activity Report Summary
Total Inforce In One-Man/Self-Employed Market as of 12/31/95

Exhibit B-1

Row #	COMPANY NAME	# OF GROUPS INFORCE YEAR 95 BASIC	YEAR 95 STD	YEAR 95 TRAD	YEAR 95 ALL PLANS	Row #
1	AETNA HEALTH PLANS OF THE CAROLINAS, INC	0	0	0	0	1
2	AETNA LIFE INS CO	0	0	0	0	2
3	ALLIANZ LIFE INS CO OF NORTH AMERICA	0	0	0	0	3
4	AMERICAN FIDELITY ASSUR CO	NR	NR	NR	NR	4
5	AMERICAN NATIONAL LIFE INS CO	0	0	13	13	5
6	AMERICAN SERVICE LIFE INS CO	N/A	N/A	N/A	N/A	6
7	BANKERS UNITED LIFE ASSUR CO	0	0	0	0	7
8	BLUE CROSS BLUE SHIELD/NC	1	78	1,255	1,334	8
9	BOSTON MUTUAL LIFE INS CO	0	0	1	1	9
10	CELTIC LIFE INS CO	NR	NR	NR	NR	10
11	CENTENNIAL LIFE INS CO	0	0	29	29	11
12	CENTRAL RESERVE LIFE INS CO	0	0	0	0	12
13	CIGNA HEALTHCARE OF NORTH CAROLINA	1	121	2	124	13
14	COLONIAL LIFE INS CO OF AMERICA	0	0	0	0	14
15	CONNECTICUT GENERAL LIFE INS CO	0	0	0	0	15
16	CUNA MUTUAL INSURANCE SOCIETY	0	0	0	0	16
17	DOCTORS HEALTH PLAN, INC	0	1	10	11	17
18	DURHAM LIFE INS CO	N/A	N/A	N/A	N/A	18
19	EMPLOYERS HEALTH INS CO	0	0	0	0	19
20	EMPLOYERS LIFE INS CO OF WAUSAU	UN	UN	UN	UN	20
21	FEDERATED MUTUAL INS CO	0	0	0	0	21
22	FIRST ALLMERICA FINANCIAL LIFE INS CO	0	0	0	0	22
23	FORTIS BENEFITS INS CO	0	0	96	96	23
24	FRANKLIN LIFE INS CO	1	5	13	19	24
25	GENERAL AMERICAN LIFE INS CO	0	0	0	0	25
26	GREAT-WEST LIFE & ANNUITY INS CO	0	0	0	0	26
27	GUARDIAN LIFE INS CO	0	0	67	67	27
28	HEALTHSOURCE, NORTH CAROLINA INC	2	21	70	93	28
29	HOME LIFE FINANCIAL ASSURANCE CORP	0	3	41	44	29
30	INDEPENDENT LIFE AND ACCIDENT INS CO	N/A	N/A	N/A	N/A	30
31	JEFFERSON-PILOT LIFE INS CO	0	0	0	0	31
32	JOHN ALDEN LIFE INS CO	NR	NR	NR	NR	32
33	JOHN HANCOCK MUTUAL LIFE INS CO	0	0	208	208	33
34	KAISER FOUNDATION HEALTH PLAN/NC	5	194	7	206	34
35	KANAWHA INS CO	0	4	41	45	35
36	LAMAR LIFE INS CO	0	0	0	0	36
37	LIFE INVESTORS INSURANCE CO OF AMER	0	0	0	0	37
38	LINCOLN NATIONAL LIFE INS CO	0	0	0	0	38
39	MAMSI LIFE AND HEALTH INS CO	UN	UN	UN	UN	39
40	MANUFACTURERS LIFE INS CO	N/A	N/A	N/A	N/A	40
41	MAXICARE NORTH CAROLINA, INC	N/A	N/A	N/A	N/A	41
42	METRAHEALTH INS CO	0	0	0	0	42
43	METROPOLITAN LIFE INS CO	0	0	0	0	43
44	MID-SOUTH INS CO	1	28	192	221	44
45	MONUMENTAL LIFE INS CO	0	0	138	138	45

1995 Small Group Activity Report Summary
Total Inforce In One-Man/Self-Employed Market as of 12/31/95

OF GROUPS INFORCE

Row #	COMPANY NAME	YEAR 95 BASIC	YEAR 95 STD	YEAR 95 TRAD	YEAR 95 ALL PLANS	Row #
46	NATIONAL AMERICAN LIFE INS CO OF PA	N/A	N/A	N/A	N/A	46
47	NATIONAL FOUNDATION LIFE INS CO	N/A	N/A	N/A	N/A	47
48	NATIONAL GROUP LIFE INS CO	0	0	111	111	48
49	NATIONAL HEALTH LIFE INS CO	0	0	170	170	49
50	NATIONWIDE LIFE INS CO	8	0	76	84	50
51	NEW ENGLAND MUTUAL LIFE INS CO	0	1	72	73	51
52	NEW YORK LIFE INS CO	0	29	271	300	52
53	OPTIMUM CHOICE OF THE CAROLINAS, INC	0	0	0	0	53
54	PACIFIC MUTUAL LIFE INS CO	0	0	8	8	54
55	PAN AMERICAN LIFE INS CO	0	0	16	16	55
56	PARTNERS NATIONAL HEALTH PLAN OF NC	8	9	6	23	56
57	PFL LIFE INS CO	17	50	7,870	7,937	57
58	PHOENIX AMERICAN LIFE INS CO	0	0	0	0	58
59	PHOENIX HOME LIFE MUTUAL INS CO	0	0	0	0	59
60	PHP, INC	1	8	172	181	60
61	PIONEER LIFE INS CO OF ILLINOIS	0	1	39	40	61
62	PRINCIPAL HEALTH CARE OF THE CAROLINAS	UN	UN	UN	UN	62
63	PRINCIPAL MUTUAL LIFE INS CO	0	71	361	432	83
64	PROTECTIVE LIFE INS CO	0	7	233	240	64
65	PROVIDENT HEALTH CARE PLAN INC OF NC	0	0	0	0	65
66	PROVIDENT LIFE & ACCIDENT INS CO	0	18	101	119	66
67	PRUDENTIAL HEALTH CARE PLAN INC	4	10	30	44	67
68	PRUDENTIAL INS CO OF AMERICA	0	13	861	874	68
69	SAVERS LIFE INS CO	N/A	N/A	N/A	N/A	69
70	SECURITY LIFE INS CO OF AMERICA	0	0	54	54	70
71	SENTRY LIFE INS CO	0	0	11	11	71
72	TIME INS CO	0	6	48	54	72
73	TMG LIFE INS CO	0	2	117	119	73
74	TRAVELERS INS CO	0	0	0	0	74
75	TRUSTMARK INSURANCE CO	0	12	282	294	75
76	UNITED OF OMAHA INS CO	1	12	198	211	76
77	UNITED STATES LIFE INS CO	0	0	0	0	77
78	UNITED WISCONSIN LIFE INS CO	1	8	1,150	1,159	78
79	UNITED WORLD LIFE INS CO	1	10	28	39	79
80	US HEALTHCARE OF THE CAROLINAS INC	0	0	0	0	80
81	WELLPATH COMMUNITY HEALTH PLANS INC	0	0	0	0	81
82	WESTERN FIDELITY INS CO	N/A	N/A	N/A	N/A	82
	TOTAL	52	722	14,468	15,242	

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COMPANY NAME IN BOLD INDICATES A RISK ASSUMING CARRIER

NATIONWIDE LIFE INS CO INCLUDES EMPLOYERS LIFE INS CO OF WAUSAU

FIRST ALLMERICA FINANCIAL LIFE INS CO WAS FORMERLY STATE MUTUAL LIFE ASSUR CO OF AMERICA

1995 Small Group Activity Report Summary
Total Inforce In 1-49 Market as of 12/31/95

Exhibit B-2

Row #	COMPANY NAME	# OF GROUPS INFORCE YEAR 95 BASIC	YEAR 95 STD	YEAR 95 TRAD	YEAR 95 ALL PLANS	# OF EMPLOYEES COVERED YEAR 95 BASIC	YEAR 95 STD	YEAR 95 TRAD	YEAR 95 ALL PLANS	AVERAGE GROUP SIZE ALL PLANS	Row #
1	AETNA HEALTH PLANS OF THE CAROLINAS, INC	0	0	1	1	0	0	11	11	11.0	1
2	AETNA LIFE INS CO	0	0	116	116	0	0	2,701	2,701	23.3	2
3	ALLIANZ LIFE INS CO OF NORTH AMERICA	0	0	4	4	0	0	8	8	2.0	3
4	AMERICAN FIDELITY ASSUR CO	NR	NR	NR	NR	NR	NR	NR	NR	NR	4
5	AMERICAN NATIONAL LIFE INS CO	0	0	68	68	0	0	471	471	6.9	5
6	AMERICAN SERVICE LIFE INS CO	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	8
7	BANKERS UNITED LIFE ASSUR CO	0	0	1	1	0	0	7	7	7.0	7
8	BLUE CROSS BLUE SHIELD/NC	2	260	10,487	10,749	3	836	83,539	84,378	7.8	8
9	BOSTON MUTUAL LIFE INS CO	0	1	74	75	0	2	303	305	4.1	9
10	CELTIC LIFE INS CO	NR	NR	NR	NR	NR	NR	NR	NR	NR	10
11	CENTENNIAL LIFE INS CO	0	0	136	136	0	0	723	723	5.3	11
12	CENTRAL RESERVE LIFE INS CO	0	10	795	805	0	20	3,918	3,938	4.9	12
13	CIGNA HEALTHCARE OF NORTH CAROLINA	1	178	46	225	1	560	920	1,481	6.6	13
14	COLONIAL LIFE INS CO OF AMERICA	0	0	26	26	0	0	394	394	15.2	14
15	CONNECTICUT GENERAL LIFE INS CO	0	0	4	4	0	0	38	38	9.5	15
16	CUNA MUTUAL INSURANCE SOCIETY	0	0	69	69	0	0	577	577	8.4	16
17	DOCTORS HEALTH PLAN, INC	0	2	15	17	0	3	57	60	3.5	17
18	DURHAM LIFE INS CO	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	18
19	EMPLOYERS HEALTH INS CO	1	58	1,087	1,146	3	174	6,459	6,836	5.8	19
20	EMPLOYERS LIFE INS CO OF WAUSAU	UN	UN	UN	UN	UN	UN	UN	UN	UN	20
21	FEDERATED MUTUAL INS CO	0	2	210	212	0	13	1,354	1,367	6.4	21
22	FIRST ALLMERICA FINANCIAL LIFE INS CO	0	0	5	5	0	0	211	211	42.2	22
23	FORTIS BENEFITS INS CO	0	4	775	779	0	27	6,322	6,349	8.2	23
24	FRANKLIN LIFE INS CO	1	6	38	45	1	44	254	299	6.6	24
25	GENERAL AMERICAN LIFE INS CO	0	13	0	13	0	269	0	269	20.7	25
26	GREAT-WEST LIFE & ANNUITY INS CO	0	0	35	35	0	0	1,540	1,540	44.0	28
27	GUARDIAN LIFE INS CO	0	4	841	845	0	11	8,186	8,197	9.7	27
28	HEALTHSOURCE, NORTH CAROLINA INC	2	42	152	196	2	244	617	863	4.4	28
29	HOME LIFE FINANCIAL ASSURANCE CORP	0	9	245	254	0	36	1,551	1,587	6.2	29
30	INDEPENDENT LIFE AND ACCIDENT INS CO	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	30
31	JEFFERSON-PILOT LIFE INS CO	0	0	194	194	0	0	5,312	5,312	27.4	31
32	JOHN ALDEN LIFE INS CO	0	122	5,686	5,808	0	480	22,955	23,435	4.0	32
33	JOHN HANCOCK MUTUAL LIFE INS CO	0	0	369	369	0	0	1,067	1,067	2.9	33
34	KAISER FOUNDATION HEALTH PLAN/NC	5	222	620	847	5	254	4,384	4,643	5.5	34
35	KANAWHA INS CO	0	4	143	147	0	42	1,261	1,303	8.9	35
36	LAMAR LIFE INS CO	0	0	4	4	0	0	29	29	7.3	38
37	LIFE INVESTORS INSURANCE CO OF AMER	0	0	123	123	0	0	136	136	1.1	37
38	LINCOLN NATIONAL LIFE INS CO	1	11	349	361	1	28	1,755	1,784	4.9	38
39	MAMSI LIFE AND HEALTH INS CO	0	3	590	593	0	3	1,671	1,674	2.8	39
40	MANUFACTURERS LIFE INS CO	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	40
41	MAXICARE NORTH CAROLINA, INC	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	41
42	METRAHEALTH INS CO	0	0	0	0	0	0	0	0	0.0	42
43	METROPOLITAN LIFE INS CO	0	1	36	37	0	10	201	211	5.7	43
44	MID-SOUTH INS CO	3	50	1,077	1,130	3	156	8,456	8,615	7.6	44
45	MONUMENTAL LIFE INS CO	0	0	295	295	0	0	534	534	1.8	45

Row #	COMPANY NAME	# OF GROUPS INFORCE YEAR 95 BASIC	YEAR 95 STD	YEAR 95 TRAD	YEAR 95 ALL PLANS	# OF EMPLOYEES COVERED YEAR 95 BASIC	YEAR 95 STD	YEAR 95 TRAD	YEAR 95 ALL PLANS	AVERAGE GROUP SIZE ALL PLANS	Row #
46	NATIONAL AMERICAN LIFE INS CO OF PA	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	48
47	NATIONAL FOUNDATION LIFE INS CO	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	47
48	NATIONAL GROUP LIFE INS CO	1	5	766	772	3	22	2,082	2,107	2.7	48
49	NATIONAL HEALTH LIFE INS CO	0	0	190	190	0	0	216	218	1.1	49
50	NATIONWIDE LIFE INS CO	19	0	683	702	36	0	4,899	4,935	7.0	50
51	NEW ENGLAND MUTUAL LIFE INS CO	0	3	431	434	0	8	2,199	2,207	5.1	51
52	NEW YORK LIFE INS CO	0	36	495	531	0	91	3,065	3,158	5.9	52
53	OPTIMUM CHOICE OF THE CAROLINAS, INC	0	0	0	0	0	0	0	0	0.0	53
54	PACIFIC MUTUAL LIFE INS CO	0	0	85	85	0	0	987	987	11.8	54
55	PAN AMERICAN LIFE INS CO	0	6	208	214	0	27	977	1,004	4.7	55
56	PARTNERS NATIONAL HEALTH PLAN OF NC	58	83	147	288	196	457	1,807	2,460	8.5	56
57	PFL LIFE INS CO	18	53	8,142	8,213	19	56	8,464	8,539	1.0	57
58	PHOENIX AMERICAN LIFE INS CO	0	0	4	4	0	0	99	99	24.8	58
59	PHOENIX HOME LIFE MUTUAL INS CO	0	0	11	11	0	0	185	185	18.8	59
60	PHP, INC	2	24	1,148	1,174	6	74	6,732	6,812	5.8	60
61	PIONEER LIFE INS CO OF ILLINOIS	1	4	264	269	2	1	808	811	3.0	81
62	PRINCIPAL HEALTH CARE OF THE CAROLINAS	1	6	0	7	2	23	0	25	3.8	82
63	PRINCIPAL MUTUAL LIFE INS CO	3	223	5,544	5,770	7	874	43,034	43,915	7.8	83
64	PROTECTIVE LIFE INS CO	0	25	542	567	0	50	1,235	1,285	2.3	64
65	PROVIDENT HEALTH CARE PLAN INC OF NC	0	0	0	0	0	0	0	0	0.0	65
66	PROVIDENT LIFE & ACCIDENT INS CO	1	29	383	413	2	83	2,025	2,110	5.1	66
67	PRUDENTIAL HEALTH CARE PLAN INC	5	32	87	124	15	111	570	696	5.8	67
68	PRUDENTIAL INS CO OF AMERICA	0	13	861	874	0	23	4,082	4,105	4.7	68
69	SAVERS LIFE INS CO	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	69
70	SECURITY LIFE INS CO OF AMERICA	0	0	62	62	0	0	104	104	1.7	70
71	SENTRY LIFE INS CO	0	0	63	63	0	0	280	280	4.4	71
72	TIME INS CO	0	9	402	411	0	13	1,248	1,261	3.1	72
73	TMG LIFE INS CO	0	12	911	923	0	36	6,630	6,666	7.2	73
74	TRAVELERS INS CO	1	67	2,354	2,422	2	286	17,288	17,576	7.3	74
75	TRUSTMARK INSURANCE CO	0	35	1,112	1,147	0	173	8,950	9,123	8.0	75
76	UNITED OF OMAHA INS CO	1	22	674	697	1	43	2,996	3,040	4.4	76
77	UNITED STATES LIFE INS CO	0	0	12	12	0	0	52	52	4.3	77
78	UNITED WISCONSIN LIFE INS CO	1	14	1,613	1,628	1	29	3,517	3,547	2.2	78
79	UNITED WORLD LIFE INS CO	1	11	66	78	1	11	237	249	3.2	79
80	US HEALTHCARE OF THE CAROLINAS INC	0	0	0	0	0	0	0	0	0.0	80
81	WELLPATH COMMUNITY HEALTH PLANS INC	0	0	0	0	0	0	0	0	0.0	81
82	WESTERN FIDELITY INS CO	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	82
	TOTAL	129	1,714	51,976	53,819	312	5,703	292,690	298,705	5.8	

COLUMN AND ROW TOTALS MAY NOT ADD CORRECTLY DUE TO SOME CARRIERS' INABILITY TO PROVIDE THE DATA IN THE DETAIL REQUIRED

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COMPANY NAME IN BOLD INDICATES A RISK ASSUMING CARRIER

NATIONWIDE LIFE INS CO INCLUDES EMPLOYERS LIFE INS CO OF WAUSAU

FIRST ALLMERICA FINANCIAL LIFE INS CO WAS FORMERLY STATE MUTUAL LIFE ASSUR CO OF AMERICA

Small Group Activity Report Summary
1992 through 1995
Number of Groups Issued - Basic Health Benefit Plan
3-25 Market

Exhibit C

Row #	COMPANY NAME	YEAR 92 # NOT PREV INS	YEAR 93 # NOT PREV INS	YEAR 94 # NOT PREV INS	YEAR 95 # NOT PREV INS	YEAR 92 # PREV INSURED	YEAR 93 # PREV INSURED	YEAR 94 # PREV INSURED	YEAR 95 # PREV INSURED	YEAR 92 # GROUPS ISSUED	YEAR 93 # GROUPS ISSUED	YEAR 94 # GROUPS ISSUED	YEAR 95 # GROUPS ISSUED	Row #
1	AETNA HEALTH PLANS OF THE CAROLINAS, INC	N/A	N/A	N/A	0	N/A	N/A	N/A	0	N/A	N/A	N/A	0	1
2	AETNA LIFE INS CO	0	0	0	0	0	0	0	0	0	0	0	0	2
3	ALLIANZ LIFE INS CO OF NORTH AMERICA	N/A	N/A	0	0	N/A	N/A	0	0	N/A	N/A	0	0	3
4	AMERICAN FIDELITY ASSUR CO	N/A	0	0	NR	N/A	0	0	NR	N/A	0	0	NR	4
5	AMERICAN NATIONAL LIFE INS CO	0	0	0	0	0	0	0	0	0	0	0	0	5
6	AMERICAN SERVICE LIFE INS CO	0	0	0	N/A	0	0	0	N/A	0	0	0	N/A	6
7	BANKERS UNITED LIFE ASSUR CO	N/A	N/A	N/A	0	N/A	N/A	N/A	0	N/A	N/A	N/A	0	7
8	BLUE CROSS BLUE SHIELD/NC	2	0	0	0	4	0	0	0	6	0	0	0	8
9	BOSTON MUTUAL LIFE INS CO	0	0	0	0	0	0	0	0	0	0	0	0	9
10	CELTIC LIFE INS CO	0	0	0	NR	0	0	0	NR	0	0	0	NR	10
11	CENTENNIAL LIFE INS CO	0	0	0	0	0	0	0	0	0	0	0	0	11
12	CENTRAL RESERVE LIFE INS CO	0	1	0	0	0	0	0	0	0	1	0	0	12
13	CIGNA HEALTHCARE OF NORTH CAROLINA	N/A	N/A	0	0	N/A	N/A	0	0	N/A	N/A	0	0	13
14	COLONIAL LIFE INS CO OF AMERICA	0	0	0	0	0	0	0	0	0	0	0	0	14
15	CONNECTICUT GENERAL LIFE INS CO	0	0	0	0	0	0	0	0	0	0	0	0	15
16	CUNA MUTUAL INSURANCE SOCIETY	0	0	0	0	0	0	0	0	0	0	0	0	16
17	DOCTORS HEALTH PLAN, INC	N/A	N/A	N/A	0	N/A	N/A	N/A	0	N/A	N/A	N/A	0	17
18	DURHAM LIFE INS CO	0	0	N/A	N/A	0	0	N/A	N/A	0	0	N/A	N/A	18
19	EMPLOYERS HEALTH INS CO	UN	UN	UN	UN	UN	UN	UN	UN	UN	UN	UN	1	19
20	EMPLOYERS LIFE INS CO OF WAUSAU	N/A	N/A	N/A	UN	N/A	N/A	N/A	UN	N/A	N/A	N/A	UN	20
21	FEDERATED MUTUAL INS CO	0	0	0	0	0	0	0	0	0	0	0	0	21
22	FIRST ALLMERICA FINANCIAL LIFE INS CO	0	0	0	0	0	0	0	0	0	0	0	0	22
23	FORTIS BENEFITS INS CO	0	0	0	0	0	0	0	0	0	0	0	0	23
24	FRANKLIN LIFE INS CO	N/A	0	0	0	N/A	0	0	0	N/A	0	0	0	24
25	GENERAL AMERICAN LIFE INS CO	N/A	N/A	N/A	0	N/A	N/A	N/A	0	N/A	N/A	N/A	0	25
26	GREAT-WEST LIFE & ANNUITY INS CO	N/A	N/A	0	0	N/A	N/A	0	0	N/A	N/A	0	0	26
27	GUARDIAN LIFE INS CO	0	0	0	0	0	0	0	0	0	0	0	0	27
28	HEALTHSOURCE, NORTH CAROLINA	N/A	N/A	0	0	N/A	N/A	0	0	N/A	N/A	0	0	28
29	HOME LIFE FINANCIAL ASSURANCE CORP	0	0	0	0	0	0	0	0	0	0	0	0	29
30	INDEPENDENT LIFE AND ACCIDENT INS CO	0	0	N/A	N/A	0	0	N/A	N/A	0	0	N/A	N/A	30
31	JEFFERSON-PILOT LIFE INS CO	0	0	0	0	0	0	0	0	0	0	0	0	31
32	JOHN ALDEN LIFE INS CO	0	0	0	0	0	0	0	0	0	0	0	0	32
33	JOHN HANCOCK MUTUAL LIFE INS CO	0	0	0	0	0	0	0	0	0	0	0	0	33
34	KAISER FOUNDATION HEALTH PLAN/NC	0	0	0	0	0	0	0	0	0	0	0	0	34
35	KANAWHA INS CO	0	0	0	0	0	0	0	0	0	0	0	0	35
36	LAMAR LIFE INS CO	0	0	0	0	0	0	0	0	0	0	0	0	38
37	LIFE INVESTORS INSURANCE CO OF AMER	N/A	N/A	0	0	N/A	N/A	0	0	N/A	N/A	0	0	37
38	LINCOLN NATIONAL LIFE INS CO	UN	0	UN	0	UN	0	UN	0	0	0	0	0	38
39	MAMSI LIFE AND HEALTH INS CO	N/A	N/A	N/A	UN	N/A	N/A	N/A	UN	N/A	N/A	N/A	UN	39
40	MANUFACTURERS LIFE INS CO	N/A	0	0	N/A	N/A	0	0	N/A	N/A	0	0	N/A	40
41	MAXICARE NORTH CAROLINA, INC	0	0	0	N/A	0	0	0	N/A	0	0	0	N/A	41
42	METRAHEALTH INS CO	N/A	N/A	N/A	0	N/A	N/A	N/A	0	N/A	N/A	N/A	0	42
43	METROPOLITAN LIFE INS CO	0	0	0	0	0	0	0	0	0	0	0	0	43
44	MID-SOUTH INS CO	0	1	1	0	0	0	0	0	0	1	1	0	44
45	MONUMENTAL LIFE INS CO	0	0	0	0	0	0	0	0	0	0	0	0	45

Small Group Activity Report Summary
1992 through 1995
Number of Groups Issued - Basic Health Benefit Plan
3-25 Market

Exhibit C

Row #	COMPANY NAME	YEAR 92 # NOT PREV INS	YEAR 93 # NOT PREV INS	YEAR 94 # NOT PREV INS	YEAR 95 # NOT PREV INS	YEAR 92 # PREV INSURED	YEAR 93 # PREV INSURED	YEAR 94 # PREV INSURED	YEAR 95 # PREV INSURED	YEAR 92 # GROUPS ISSUED	YEAR 93 # GROUPS ISSUED	YEAR 94 # GROUPS ISSUED	YEAR 95 # GROUPS ISSUED	Row #
46	NATIONAL AMERICAN LIFE INS CO OF PA	0	0	N/A	N/A	0	0	N/A	N/A	0	0	N/A	N/A	46
47	NATIONAL FOUNDATION LIFE INS CO	0	0	N/A	N/A	0	0	N/A	N/A	0	0	N/A	N/A	47
48	NATIONAL GROUP LIFE INS CO	0	0	0	UN	0	0	0	UN	0	0	0	1	48
49	NATIONAL HEALTH LIFE INS CO	0	0	0	0	0	0	0	0	0	0	0	0	49
50	NATIONWIDE LIFE INS CO	0	2	2	UN	0	0	0	UN	0	2	2	1	50
51	NEW ENGLAND MUTUAL LIFE INS CO	0	0	0	0	0	0	0	0	0	0	0	0	51
52	NEW YORK LIFE INS CO	1	0	0	0	1	0	0	0	2	0	0	0	52
53	OPTIMUM CHOICE OF THE CAROLINAS, INC	N/A	N/A	N/A	0	N/A	N/A	N/A	0	N/A	N/A	N/A	0	53
54	PACIFIC MUTUAL LIFE INS CO	0	0	0	0	0	0	0	0	0	0	0	0	54
55	PAN AMERICAN LIFE INS CO	0	0	0	0	0	0	0	0	0	0	0	0	55
56	PARTNERS NATIONAL HEALTH PLAN OF NC	0	4	1	5	1	1	3	25	1	5	4	30	56
57	PFL LIFE INS CO	N/A	N/A	N/A	0	N/A	N/A	N/A	0	N/A	N/A	N/A	0	57
58	PHOENIX AMERICAN LIFE INS CO	0	0	0	0	0	0	0	0	0	0	0	0	58
59	PHOENIX HOME LIFE MUTUAL INS CO	N/A	N/A	0	0	N/A	N/A	0	0	N/A	N/A	0	0	59
60	PHP, INC	0	0	0	UN	0	0	0	UN	0	0	0	1	60
61	PIONEER LIFE INS CO OF ILLINOIS	0	0	0	0	0	0	0	0	0	0	0	0	61
62	PRINCIPAL HEALTH CARE OF THE CAROLINAS	N/A	N/A	N/A	UN	N/A	N/A	N/A	UN	N/A	N/A	N/A	UN	62
63	PRINCIPAL MUTUAL LIFE INS CO	0	1	1	0	0	0	0	0	0	1	1	0	63
64	PROTECTIVE LIFE INS CO	0	0	0	0	0	0	1	0	0	0	1	0	64
65	PROVIDENT HEALTH CARE PLAN INC OF NC	N/A	N/A	N/A	0	N/A	N/A	N/A	0	N/A	N/A	N/A	0	65
66	PROVIDENT LIFE & ACCIDENT INS CO	N/A	N/A	0	0	N/A	N/A	0	1	N/A	N/A	0	1	66
67	PRUDENTIAL HEALTH CARE PLAN INC	UN	UN	UN	0	UN	UN	UN	1	UN	UN	UN	1	67
68	PRUDENTIAL INS CO OF AMERICA	0	0	0	0	0	0	0	0	0	0	0	0	68
69	SAVERS LIFE INS CO	0	0	N/A	N/A	0	0	N/A	N/A	0	0	N/A	N/A	69
70	SECURITY LIFE INS CO OF AMERICA	N/A	N/A	N/A	0	N/A	N/A	N/A	0	N/A	N/A	N/A	0	70
71	SENTRY LIFE INS CO	0	0	0	0	0	0	0	0	0	0	0	0	71
72	TIME INS CO	0	0	0	0	0	0	0	0	0	0	0	0	72
73	TMG LIFE INS CO	0	0	0	0	0	0	0	0	0	0	0	0	73
74	TRAVELERS INS CO	0	0	0	0	0	0	0	0	0	0	0	0	74
75	TRUSTMARK INSURANCE CO	0	0	0	0	0	0	0	0	0	0	0	0	75
76	UNITED OF OMAHA INS CO	0	0	0	0	0	0	1	0	0	0	1	0	76
77	UNITED STATES LIFE INS CO	0	0	0	0	0	0	0	0	0	0	0	0	77
78	UNITED WISCONSIN LIFE INS CO	N/A	N/A	0	0	N/A	N/A	0	0	N/A	N/A	0	0	78
79	UNITED WORLD LIFE INS CO	0	0	0	0	0	0	0	0	0	0	0	0	79
80	US HEALTHCARE OF THE CAROLINAS, INC	N/A	N/A	N/A	0	N/A	N/A	N/A	0	N/A	N/A	N/A	0	80
81	WELLPATH COMMUNITY HEALTH PLANS INC	N/A	N/A	N/A	0	N/A	N/A	N/A	0	N/A	N/A	N/A	0	81
82	WESTERN FIDELITY INS CO	0	0	0	N/A	0	0	0	N/A	0	0	0	N/A	82
	TOTAL	3	9	5	5	6	1	5	27	9	10	10	36	

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COMPANY NAME IN BOLD INDICATES A RISK ASSUMING CARRIER

NATIONWIDE LIFE INS CO INCLUDES EMPLOYERS LIFE INS CO OF WAUSAU
FIRST ALLMERICA FINANCIAL LIFE INS CO WAS FORMERLY STATE MUTUAL LIFE ASSUR CO OF AMERICA

Small Group Activity Report Summary
1992 through 1995
Number of Groups Issued - Standard Health Benefit Plan
3-25 Market

Exhibit D

Row #	COMPANY NAME	YEAR 92 # NOT PREV INS	YEAR 93 # NOT PREV INS	YEAR 94 # NOT PREV INS	YEAR 95 # NOT PREV INS	YEAR 92 # PREV INSURED	YEAR 93 # PREV INSURED	YEAR 94 # PREV INSURED	YEAR 95 # PREV INSURED	YEAR 92 # GROUPS ISSUED	YEAR 93 # GROUPS ISSUED	YEAR 94 # GROUPS ISSUED	YEAR 95 # GROUPS ISSUED	Row #
1	AETNA HEALTH PLANS OF THE CAROLINAS, INC	N/A	N/A	N/A	0	N/A	N/A	N/A	0	N/A	N/A	N/A	0	1
2	AETNA LIFE INS CO	0	0	0	0	0	0	0	0	0	0	0	0	2
3	ALLIANZ LIFE INS CO OF NORTH AMERICA	N/A	N/A	0	0	N/A	N/A	0	0	N/A	N/A	0	0	3
4	AMERICAN FIDELITY ASSUR CO	N/A	0	0	NR	N/A	0	1	NR	N/A	0	1	NR	4
5	AMERICAN NATIONAL LIFE INS CO	0	0	0	0	0	0	0	0	0	0	0	0	5
6	AMERICAN SERVICE LIFE INS CO	0	0	0	N/A	0	0	0	N/A	0	0	0	N/A	6
7	BANKERS UNITED LIFE ASSUR CO	N/A	N/A	N/A	0	N/A	N/A	N/A	0	N/A	N/A	N/A	0	7
8	BLUE CROSS BLUE SHIELD/NC	10	19	17	25	5	19	10	9	15	38	27	34	8
9	BOSTON MUTUAL LIFE INS CO	0	0	0	0	0	0	0	0	0	0	0	0	9
10	CELTIC LIFE INS CO	0	0	0	NR	0	1	0	NR	0	1	0	NR	10
11	CENTENNIAL LIFE INS CO	0	UN	0	0	1	UN	1	0	1	1	1	0	11
12	CENTRAL RESERVE LIFE INS CO	1	11	0	0	0	1	1	0	1	12	1	0	12
13	CIGNA HEALTHCARE OF NORTH CAROLINA	N/A	N/A	3	6	N/A	N/A	20	30	N/A	N/A	23	36	13
14	COLONIAL LIFE INS CO OF AMERICA	0	UN	0	0	0	UN	0	0	0	2	0	0	14
15	CONNECTICUT GENERAL LIFE INS CO	0	0	0	0	0	0	0	0	0	0	0	0	15
16	CUNA MUTUAL INSURANCE SOCIETY	0	0	0	0	0	0	0	0	0	0	0	0	16
17	DOCTORS HEALTH PLAN, INC	N/A	N/A	N/A	0	N/A	N/A	N/A	0	N/A	N/A	N/A	0	17
18	DURHAM LIFE INS CO	0	3	N/A	N/A	1	0	N/A	N/A	1	3	N/A	N/A	18
19	EMPLOYERS HEALTH INS CO	UN	UN	UN	UN	UN	UN	UN	UN	UN	UN	UN	16	19
20	EMPLOYERS LIFE INS CO OF WAUSAU	N/A	N/A	N/A	UN	N/A	N/A	N/A	UN	N/A	N/A	N/A	UN	20
21	FEDERATED MUTUAL INS CO	1	0	0	0	0	1	0	2	1	1	0	2	21
22	FIRST ALLMERICA FINANCIAL LIFE INS CO	0	0	0	0	0	0	0	0	0	0	0	0	22
23	FORTIS BENEFITS INS CO	2	3	0	UN	1	6	0	UN	3	9	0	4	23
24	FRANKLIN LIFE INS CO	N/A	0	0	0	N/A	0	0	2	N/A	0	0	2	24
25	GENERAL AMERICAN LIFE INS CO	N/A	N/A	N/A	0	N/A	N/A	N/A	0	N/A	N/A	N/A	0	25
26	GREAT-WEST LIFE & ANNUITY INS CO	N/A	N/A	0	0	N/A	N/A	0	0	N/A	N/A	0	0	26
27	GUARDIAN LIFE INS CO	1	0	0	0	0	0	0	0	1	0	0	0	27
28	HEALTHSOURCE, NORTH CAROLINA	N/A	N/A	0	3	N/A	N/A	2	12	N/A	N/A	2	15	28
29	HOME LIFE FINANCIAL ASSURANCE CORP	0	1	1	0	0	5	0	3	0	6	1	3	29
30	INDEPENDENT LIFE AND ACCIDENT INS CO	0	0	N/A	N/A	0	0	N/A	N/A	0	0	N/A	N/A	30
31	JEFFERSON-PILOT LIFE INS CO	UN	1	0	0	UN	0	0	0	0	1	0	0	31
32	JOHN ALDEN LIFE INS CO	6	23	16	12	4	26	2	35	10	51	16	47	32
33	JOHN HANCOCK MUTUAL LIFE INS CO	0	0	0	0	0	0	0	0	0	0	0	0	33
34	KAISER FOUNDATION HEALTH PLAN/NC	0	UN	0	UN	0	UN	0	UN	0	1	0	24	34
35	KANAWHA INS CO	0	0	0	0	0	7	0	0	0	7	0	0	35
36	LAMAR LIFE INS CO	0	0	0	0	0	0	0	0	0	0	0	0	36
37	LIFE INVESTORS INSURANCE CO OF AMER	N/A	N/A	0	0	N/A	N/A	0	0	N/A	N/A	0	0	37
38	LINCOLN NATIONAL LIFE INS CO	UN	UN	UN	UN	UN	UN	UN	UN	0	6	8	1	38
39	MAMSI LIFE AND HEALTH INS CO	N/A	N/A	N/A	UN	N/A	N/A	N/A	UN	N/A	N/A	N/A	UN	39
40	MANUFACTURERS LIFE INS CO	N/A	0	0	N/A	N/A	1	0	N/A	N/A	1	0	N/A	40
41	MAXICARE NORTH CAROLINA, INC	0	0	0	N/A	0	0	0	N/A	0	0	0	N/A	41
42	METRAHEALTH INS CO	N/A	N/A	N/A	0	N/A	N/A	N/A	0	N/A	N/A	N/A	0	42
43	METROPOLITAN LIFE INS CO	0	0	1	0	0	0	0	0	0	0	1	0	43
44	MID-SOUTH INS CO	0	0	4	10	0	1	1	5	0	1	5	15	44
45	MONUMENTAL LIFE INS CO	0	0	0	0	0	0	0	0	0	0	0	0	45

Small Group Activity Report Summary
1992 through 1995
Number of Groups Issued - Standard Health Benefit Plan
3-25 Market

Exhibit D

Row #	COMPANY NAME	YEAR 92 # NOT PREV INS	YEAR 93 # NOT PREV INS	YEAR 94 # NOT PREV INS	YEAR 95 # NOT PREV INS	YEAR 92 # PREV INSURED	YEAR 93 # PREV INSURED	YEAR 94 # PREV INSURED	YEAR 95 # PREV INSURED	YEAR 92 # GROUPS ISSUED	YEAR 93 # GROUPS ISSUED	YEAR 94 # GROUPS ISSUED	YEAR 95 # GROUPS ISSUED	Row #
46	NATIONAL AMERICAN LIFE INS CO OF PA	0	0	N/A	N/A	0	0	N/A	N/A	0	0	N/A	N/A	46
47	NATIONAL FOUNDATION LIFE INS CO	0	0	N/A	N/A	0	0	N/A	N/A	0	0	N/A	N/A	47
48	NATIONAL GROUP LIFE INS CO	0	0	0	UN	0	0	0	UN	0	0	0	4	48
49	NATIONAL HEALTH LIFE INS CO	0	0	0	0	0	0	0	0	0	0	0	0	49
50	NATIONWIDE LIFE INS CO	0	4	2	0	0	0	0	0	0	4	2	0	50
51	NEW ENGLAND MUTUAL LIFE INS CO	0	1	0	2	0	0	0	0	0	1	0	2	51
52	NEW YORK LIFE INS CO	6	9	4	3	1	9	2	2	7	16	8	5	52
53	OPTIMUM CHOICE OF THE CAROLINAS, INC	N/A	N/A	N/A	0	N/A	N/A	N/A	0	N/A	N/A	N/A	0	53
54	PACIFIC MUTUAL LIFE INS CO	0	0	0	0	0	0	0	0	0	0	0	0	54
55	PAN AMERICAN LIFE INS CO	0	2	0	0	0	6	2	0	0	6	2	0	55
56	PARTNERS NATIONAL HEALTH PLAN OF NC	1	2	5	6	1	1	7	40	2	3	12	48	58
57	PFL LIFE INS CO	N/A	N/A	N/A	0	N/A	N/A	N/A	0	N/A	N/A	N/A	0	57
58	PHOENIX AMERICAN LIFE INS CO	0	0	0	0	0	0	0	0	0	0	0	0	58
59	PHOENIX HOME LIFE MUTUAL INS CO	N/A	N/A	0	0	N/A	N/A	0	0	N/A	N/A	0	0	59
60	PHP, INC	0	0	UN	UN	0	0	UN	UN	0	0	1	11	80
61	PIONEER LIFE INS CO OF ILLINOIS	0	0	0	0	0	0	0	0	0	0	0	0	61
62	PRINCIPAL HEALTH CARE OF THE CAROLINAS	N/A	N/A	N/A	UN	N/A	N/A	N/A	UN	N/A	N/A	N/A	UN	62
63	PRINCIPAL MUTUAL LIFE INS CO	10	10	46	31	6	9	12	11	16	19	58	42	83
64	PROTECTIVE LIFE INS CO	1	2	1	1	0	3	2	1	1	5	3	2	84
65	PROVIDENT HEALTH CARE PLAN INC OF NC	N/A	N/A	N/A	0	N/A	N/A	N/A	0	N/A	N/A	N/A	0	65
66	PROVIDENT LIFE & ACCIDENT INS CO	N/A	N/A	1	2	N/A	N/A	1	0	N/A	N/A	2	2	68
67	PRUDENTIAL HEALTH CARE PLAN INC	UN	UN	UN	7	UN	UN	UN	4	UN	UN	UN	11	87
68	PRUDENTIAL INS CO OF AMERICA	0	0	3	2	0	0	0	1	0	0	3	3	88
69	SAVERS LIFE INS CO	0	0	N/A	N/A	0	0	N/A	N/A	0	0	N/A	N/A	89
70	SECURITY LIFE INS CO OF AMERICA	N/A	N/A	N/A	0	N/A	N/A	N/A	0	N/A	N/A	N/A	0	70
71	SENTRY LIFE INS CO	0	0	0	0	0	0	0	0	0	0	0	0	71
72	TIME INS CO	0	0	0	0	0	4	0	0	0	4	0	0	72
73	TMG LIFE INS CO	1	1	UN	1	1	2	UN	3	2	3	1	4	73
74	TRAVELERS INS CO	0	0	1	9	0	0	8	16	0	0	9	25	74
75	TRUSTMARK INSURANCE CO	0	1	0	6	0	1	4	3	0	2	4	9	75
76	UNITED OF OMAHA INS CO	UN	0	0	4	UN	2	0	1	0	2	0	5	76
77	UNITED STATES LIFE INS CO	0	0	0	0	0	1	0	0	0	1	0	0	77
78	UNITED WISCONSIN LIFE INS CO	N/A	N/A	0	0	N/A	N/A	0	2	N/A	N/A	0	2	78
79	UNITED WORLD LIFE INS CO	0	0	0	0	0	0	0	0	0	0	0	0	79
80	US HEALTHCARE OF THE CAROLINAS, INC	N/A	N/A	N/A	0	N/A	N/A	N/A	0	N/A	N/A	N/A	0	80
81	WELLPATH COMMUNITY HEALTH PLANS INC	N/A	N/A	N/A	0	N/A	N/A	N/A	0	N/A	N/A	N/A	0	81
82	WESTERN FIDELITY INS CO	0	0	0	N/A	0	0	1	N/A	0	0	1	N/A	82
	TOTAL	40	93	105	130	23	108	77	182	63	213	192	372	

COLUMN AND ROW TOTALS MAY NOT ADD CORRECTLY DUE TO SOME CARRIERS' INABILITY TO PROVIDE THE DATA IN THE DETAIL REQUIRED

UN = UNKNOWN
N/A = NOT APPLICABLE
NR = NOT REPORTED

COMPANY NAME IN BOLD INDICATES A RISK ASSUMING CARRIER

NATIONWIDE LIFE INS CO INCLUDES EMPLOYERS LIFE INS CO OF WAUSAU
FIRST ALLMERICA FINANCIAL LIFE INS CO WAS FORMERLY STATE MUTUAL LIFE ASSUR CO OF AMERICA

Small Group Activity Report Summary
1992 through 1995
Number of Groups Issued - Traditional Health Benefit Plans
3-25 Market

Exhibit E

Row #	COMPANY NAME	YEAR 92 # NOT PREV INS	YEAR 93 # NOT PREV INS	YEAR 94 # NOT PREV INS	YEAR 95 # NOT PREV INS	YEAR 92 # PREV INSURED	YEAR 93 # PREV INSURED	YEAR 94 # PREV INSURED	YEAR 95 # PREV INSURED	YEAR 92 # GROUPS ISSUED	YEAR 93 # GROUPS ISSUED	YEAR 94 # GROUPS ISSUED	YEAR 95 # GROUPS ISSUED	Row #
1	AETNA HEALTH PLANS OF THE CAROLINAS, INC	N/A	N/A	N/A	0	N/A	N/A	N/A	0	N/A	N/A	N/A	0	1
2	AETNA LIFE INS CO	1	15	0	0	16	1	14	9	17	16	14	9	2
3	ALLIANZ LIFE INS CO OF NORTH AMERICA	N/A	N/A	0	0	N/A	N/A	0	3	N/A	N/A	0	3	3
4	AMERICAN FIDELITY ASSUR CO	N/A	0	0	NR	N/A	0	34	NR	N/A	0	34	NR	4
5	AMERICAN NATIONAL LIFE INS CO	1	2	0	6	5	1	1	25	8	3	1	31	5
6	AMERICAN SERVICE LIFE INS CO	125	0	0	N/A	0	0	0	N/A	125	0	0	N/A	6
7	BANKERS UNITED LIFE ASSUR CO	N/A	N/A	N/A	0	N/A	N/A	N/A	0	N/A	N/A	N/A	0	7
8	BLUE CROSS BLUE SHIELD/NC	297	202	242	441	709	630	306	579	1,006	832	648	1,020	8
9	BOSTON MUTUAL LIFE INS CO	3	95	3	6	43	73	8	9	46	168	11	15	9
10	CELTIC LIFE INS CO	4	2	UN	NR	4	2	UN	NR	8	4	2	NR	10
11	CENTENNIAL LIFE INS CO	11	UN	3	5	47	UN	2	22	58	31	5	27	11
12	CENTRAL RESERVE LIFE INS CO	30	83	58	83	15	41	41	72	45	124	99	155	12
13	CIGNA HEALTHCARE OF NORTH CAROLINA	N/A	N/A	2	1	N/A	N/A	6	21	N/A	N/A	8	22	13
14	COLONIAL LIFE INS CO OF AMERICA	37	UN	UN	UN	10	UN	UN	UN	47	42	3	4	14
15	CONNECTICUT GENERAL LIFE INS CO	0	0	0	0	0	3	0	0	0	3	0	0	15
16	CUNA MUTUAL INSURANCE SOCIETY	0	0	0	UN	1	0	0	UN	1	0	0	2	18
17	DOCTORS HEALTH PLAN, INC	N/A	N/A	N/A	UN	N/A	N/A	N/A	UN	N/A	N/A	N/A	4	17
18	DURHAM LIFE INS CO	15	23	N/A	N/A	6	15	N/A	N/A	21	38	N/A	N/A	18
19	EMPLOYERS HEALTH INS CO	UN	UN	UN	UN	UN	UN	UN	UN	UN	UN	UN	214	19
20	EMPLOYERS LIFE INS CO OF WAUSAU	N/A	N/A	N/A	UN	N/A	N/A	N/A	UN	N/A	N/A	N/A	UN	20
21	FEDERATED MUTUAL INS CO	1	10	16	94	2	16	7	75	3	26	23	169	21
22	FIRST ALLMERICA FINANCIAL LIFE INS CO	0	0	0	0	0	0	0	0	0	0	0	0	22
23	FORTIS BENEFITS INS CO	9	31	UN	UN	29	19	UN	UN	38	50	122	271	23
24	FRANKLIN LIFE INS CO	N/A	2	1	4	N/A	0	8	6	N/A	2	9	10	24
25	GENERAL AMERICAN LIFE INS CO	N/A	N/A	N/A	0	N/A	N/A	N/A	0	N/A	N/A	N/A	0	25
26	GREAT-WEST LIFE & ANNUITY INS CO	N/A	N/A	0	0	N/A	N/A	0	10	N/A	N/A	0	10	28
27	GUARDIAN LIFE INS CO	45	89	31	6	34	98	52	18	79	187	83	24	27
28	HEALTHSOURCE, NORTH CAROLINA	N/A	N/A	2	50	N/A	N/A	10	3	N/A	N/A	12	53	28
29	HOME LIFE FINANCIAL ASSURANCE CORP	16	19	2	0	78	30	64	30	94	49	88	30	29
30	INDEPENDENT LIFE AND ACCIDENT INS CO	0	4	N/A	N/A	2	2	N/A	N/A	2	8	N/A	N/A	30
31	JEFFERSON-PILOT LIFE INS CO	0	0	1	1	0	0	11	12	0	0	12	13	31
32	JOHN ALDEN LIFE INS CO	564	480	779	246	298	310	374	379	862	790	1,153	625	32
33	JOHN HANCOCK MUTUAL LIFE INS CO	0	0	0	0	5	7	6	0	5	7	8	0	33
34	KAISER FOUNDATION HEALTH PLAN/NC	UN	UN	UN	UN	UN	UN	UN	UN	274	69	109	151	34
35	KANAWHA INS CO	0	0	9	20	92	108	12	29	92	108	21	49	35
36	LAMAR LIFE INS CO	6	0	0	0	4	0	0	1	10	0	0	1	38
37	LIFE INVESTORS INSURANCE CO OF AMER	N/A	N/A	0	0	N/A	N/A	0	0	N/A	N/A	0	0	37
38	LINCOLN NATIONAL LIFE INS CO	UN	UN	UN	UN	UN	UN	UN	UN	155	178	226	58	38
39	MAMSI LIFE AND HEALTH INS CO	N/A	N/A	N/A	UN	N/A	N/A	N/A	UN	N/A	N/A	N/A	UN	39
40	MANUFACTURERS LIFE INS CO	N/A	0	0	N/A	N/A	30	0	N/A	N/A	30	0	N/A	40
41	MAXICARE NORTH CAROLINA, INC	0	0	0	N/A	0	0	0	N/A	0	0	0	N/A	41
42	METRAHEALTH INS CO	N/A	N/A	N/A	0	N/A	N/A	N/A	0	N/A	N/A	N/A	0	42
43	METROPOLITAN LIFE INS CO	26	25	54	0	13	2	13	0	39	27	67	0	43
44	MID-SOUTH INS CO	3	2	67	66	12	418	106	122	15	420	173	188	44
45	MONUMENTAL LIFE INS CO	0	UN	3	0	208	UN	1	0	208	21	4	0	45

Small Group Activity Report Summary
1992 through 1995
Number of Groups Issued - Traditional Health Benefit Plans
3-25 Market

Row #	COMPANY NAME	YEAR 92 # NOT PREV INS	YEAR 93 # NOT PREV INS	YEAR 94 # NOT PREV INS	YEAR 95 # NOT PREV INS	YEAR 92 # PREV INSURED	YEAR 93 # PREV INSURED	YEAR 94 # PREV INSURED	YEAR 95 # PREV INSURED	YEAR 92 # GROUPS ISSUED	YEAR 93 # GROUPS ISSUED	YEAR 94 # GROUPS ISSUED	YEAR 95 # GROUPS ISSUED	Row #
46	NATIONAL AMERICAN LIFE INS CO OF PA	UN	0	N/A	N/A	UN	27	N/A	N/A	2	27	N/A	N/A	48
47	NATIONAL FOUNDATION LIFE INS CO	0	0	N/A	N/A	0	0	N/A	N/A	0	0	N/A	N/A	47
48	NATIONAL GROUP LIFE INS CO	0	0	UN	UN	0	79	UN	UN	0	79	112	183	48
49	NATIONAL HEALTH LIFE INS CO	UN	0	0	0	UN	0	0	0	7	0	0	0	49
50	NATIONWIDE LIFE INS CO	46	115	109	UN	4	37	47	UN	50	152	158	72	50
51	NEW ENGLAND MUTUAL LIFE INS CO	44	50	7	114	63	45	10	175	107	95	17	269	51
52	NEW YORK LIFE INS CO	46	80	23	29	37	46	52	36	63	108	75	65	52
53	OPTIMUM CHOICE OF THE CAROLINAS, INC	N/A	N/A	N/A	0	N/A	N/A	N/A	0	N/A	N/A	N/A	0	53
54	PACIFIC MUTUAL LIFE INS CO	5	10	UN	10	11	16	UN	9	18	28	18	19	54
55	PAN AMERICAN LIFE INS CO	20	45	24	0	6	33	6	0	26	78	32	0	55
58	PARTNERS NATIONAL HEALTH PLAN OF NC	1	2	9	19	11	10	8	64	12	12	15	63	56
57	PFL LIFE INS CO	N/A	N/A	N/A	3	N/A	N/A	N/A	24	N/A	N/A	N/A	27	57
56	PHOENIX AMERICAN LIFE INS CO	2	0	0	0	2	0	0	0	4	0	0	0	56
59	PHOENIX HOME LIFE MUTUAL INS CO	N/A	N/A	0	0	N/A	N/A	1	0	N/A	N/A	1	0	59
60	PHP, INC	1	UN	UN	UN	22	UN	UN	UN	23	156	300	331	60
61	PIONEER LIFE INS CO OF ILLINOIS	0	0	UN	UN	0	0	UN	UN	0	0	5	15	81
62	PRINCIPAL HEALTH CARE OF THE CAROLINAS	N/A	N/A	N/A	UN	N/A	N/A	N/A	UN	N/A	N/A	N/A	UN	62
63	PRINCIPAL MUTUAL LIFE INS CO	348	600	1,075	401	573	678	471	162	921	1,278	1,548	563	83
64	PROTECTIVE LIFE INS CO	51	13	12	12	51	13	25	23	102	26	37	35	64
65	PROVIDENT HEALTH CARE PLAN INC OF NC	N/A	N/A	N/A	0	N/A	N/A	N/A	0	N/A	N/A	N/A	0	65
66	PROVIDENT LIFE & ACCIDENT INS CO	N/A	N/A	31	53	N/A	N/A	43	70	N/A	N/A	74	123	68
67	PRUDENTIAL HEALTH CARE PLAN INC	UN	UN	UN	6	UN	UN	UN	17	UN	UN	UN	23	67
68	PRUDENTIAL INS CO OF AMERICA	84	58	41	22	49	45	95	28	133	101	136	46	68
69	SAVERS LIFE INS CO	0	0	N/A	N/A	0	0	NA	N/A	0	0	N/A	N/A	69
70	SECURITY LIFE INS CO OF AMERICA	N/A	N/A	N/A	UN	N/A	N/A	N/A	UN	N/A	N/A	N/A	1	70
71	SENTRY LIFE INS CO	5	2	1	6	3	3	1	3	6	5	2	9	71
72	TIME INS CO	20	16	22	6	43	26	38	24	63	46	60	30	72
73	TMG LIFE INS CO	124	44	UN	22	66	192	UN	190	212	236	125	212	73
74	TRAVELERS INS CO	0	156	113	80	665	1,024	564	347	665	1,160	697	427	74
75	TRUSTMARK INSURANCE CO	2	10	16	77	51	59	54	247	53	69	70	324	75
76	UNITED OF OMAHA INS CO	UN	57	50	71	UN	34	46	72	UN	91	96	143	78
77	UNITED STATES LIFE INS CO	3	0	0	0	0	13	0	0	3	13	0	0	77
78	UNITED WISCONSIN LIFE INS CO	N/A	N/A	3	0	N/A	N/A	53	199	N/A	N/A	56	199	76
79	UNITED WORLD LIFE INS CO	UN	5	3	13	UN	2	2	13	11	7	5	26	79
80	US HEALTHCARE OF THE CAROLINAS, INC	N/A	N/A	N/A	0	N/A	N/A	N/A	0	N/A	N/A	N/A	0	80
61	WELLPATH COMMUNITY HEALTH PLANS INC	N/A	N/A	N/A	0	N/A	N/A	N/A	0	N/A	N/A	N/A	0	61
62	WESTERN FIDELITY INS CO	3	7	2	N/A	8	7	2	N/A	11	14	4	N/A	62
	TOTAL	1,999	2,334	2,814	1,973	3,340	4,199	2,614	3,126	5,766	7,030	6,450	8,365	

COLUMN AND ROW TOTALS MAY NOT ADD CORRECTLY DUE TO SOME CARRIERS' INABILITY TO PROVIDE THE DATA IN THE DETAIL REQUIRED

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COMPANY NAME IN BOLD INDICATES A RISK ASSUMING CARRIER

NATIONWIDE LIFE INS CO INCLUDES EMPLOYERS LIFE INS CO OF WAUSAU

FIRST ALLMERICA FINANCIAL LIFE INS CO WAS FORMERLY STATE MUTUAL LIFE ASSUR CO OF AMERICA

Small Group Activity Report Summary
1992 through 1995
Number of Groups Issued - All Health Benefit Plans
3-25 Market

Exhibit F

Row #	COMPANY NAME	YEAR 92 # NOT PREV INS	YEAR 93 # NOT PREV INS	YEAR 94 # NOT PREV INS	YEAR 95 # NOT PREV INS	YEAR 92 # PREV INSURED	YEAR 93 # PREV INSURED	YEAR 94 # PREV INSURED	YEAR 95 # PREV INSURED	YEAR 92 # GROUPS ISSUED	YEAR 93 # GROUPS ISSUED	YEAR 94 # GROUPS ISSUED	YEAR 95 # GROUPS ISSUED	Row #
1	AETNA HEALTH PLANS OF THE CAROLINAS, INC	N/A	N/A	N/A	0	N/A	N/A	N/A	0	N/A	N/A	N/A	0	1
2	AETNA LIFE INS CO	1	15	0	0	16	1	14	9	17	16	14	9	2
3	ALLIANZ LIFE INS CO OF NORTH AMERICA	N/A	N/A	0	0	N/A	N/A	0	3	N/A	N/A	0	3	3
4	AMERICAN FIDELITY ASSUR CO	N/A	0	0	NR	N/A	0	35	NR	N/A	0	35	0	4
5	AMERICAN NATIONAL LIFE INS CO	1	2	0	6	5	1	1	25	6	3	1	31	5
6	AMERICAN SERVICE LIFE INS CO	125	0	0	N/A	0	0	0	N/A	125	0	0	N/A	6
7	BANKERS UNITED LIFE ASSUR CO	N/A	N/A	N/A	0	N/A	N/A	N/A	0	N/A	N/A	N/A	0	7
8	BLUE CROSS BLUE SHIELD/NC	309	221	259	466	718	649	316	588	1,027	870	575	1,054	8
9	BOSTON MUTUAL LIFE INS CO	3	95	3	6	43	73	8	9	46	168	11	15	9
10	CELTIC LIFE INS CO	4	2	0	NR	4	3	0	NR	8	5	2	0	10
11	CENTENNIAL LIFE INS CO	11	UN	3	5	48	UN	3	22	59	32	6	27	11
12	CENTRAL RESERVE LIFE INS CO	31	95	58	83	15	42	42	72	46	137	100	155	12
13	CIGNA HEALTHCARE OF NORTH CAROLINA	N/A	N/A	5	7	N/A	N/A	26	51	N/A	N/A	31	58	13
14	COLONIAL LIFE INS CO OF AMERICA	37	0	0	0	10	0	0	0	47	44	3	4	14
15	CONNECTICUT GENERAL LIFE INS CO	0	0	0	0	0	3	0	0	0	3	0	0	15
16	CUNA MUTUAL INSURANCE SOCIETY	0	0	0	UN	1	0	0	UN	1	0	0	2	16
17	DOCTORS HEALTH PLAN, INC	N/A	N/A	N/A	UN	N/A	N/A	N/A	UN	N/A	N/A	N/A	4	17
18	DURHAM LIFE INS CO	15	26	N/A	N/A	7	15	N/A	N/A	22	41	N/A	N/A	18
19	EMPLOYERS HEALTH INS CO	UN	UN	UN	UN	UN	UN	UN	UN	UN	UN	UN	231	19
20	EMPLOYERS LIFE INS CO OF WAUSAU	N/A	N/A	N/A	UN	N/A	N/A	N/A	UN	N/A	N/A	N/A	UN	20
21	FEDERATED MUTUAL INS CO	2	10	16	94	2	17	7	77	4	27	23	171	21
22	FIRST ALLMERICA FINANCIAL LIFE INS CO	0	0	0	0	0	0	0	0	0	0	0	0	22
23	FORTIS BENEFITS INS CO	11	34	UN	0	30	25	UN	0	41	59	122	275	23
24	FRANKLIN LIFE INS CO	N/A	2	1	4	N/A	0	8	8	N/A	2	9	12	24
25	GENERAL AMERICAN LIFE INS CO	N/A	N/A	N/A	0	N/A	N/A	N/A	0	N/A	N/A	N/A	0	25
26	GREAT-WEST LIFE & ANNUITY INS CO	N/A	N/A	0	0	N/A	N/A	0	10	N/A	N/A	0	10	26
27	GUARDIAN LIFE INS CO	46	89	31	6	34	98	52	18	80	187	83	24	27
28	HEALTHSOURCE, NORTH CAROLINA	N/A	N/A	2	53	N/A	N/A	12	15	N/A	N/A	14	68	28
29	HOME LIFE FINANCIAL ASSURANCE CORP	16	20	3	0	78	35	64	33	94	55	67	33	29
30	INDEPENDENT LIFE AND ACCIDENT INS CO	0	4	N/A	N/A	2	2	N/A	N/A	2	6	N/A	N/A	30
31	JEFFERSON-PILOT LIFE INS CO	0	1	1	1	0	0	11	12	0	1	12	13	31
32	JOHN ALDEN LIFE INS CO	570	503	795	258	302	338	376	414	872	841	1,171	672	32
33	JOHN HANCOCK MUTUAL LIFE INS CO	0	0	0	0	5	7	6	0	5	7	6	0	33
34	KAISER FOUNDATION HEALTH PLAN/NC	UN	UN	UN	UN	UN	UN	UN	UN	274	70	109	175	34
35	KANAWHA INS CO	0	0	9	20	92	115	12	29	92	115	21	49	35
36	LAMAR LIFE INS CO	6	0	0	0	4	0	0	1	10	0	0	1	36
37	LIFE INVESTORS INSURANCE CO OF AMER	N/A	NA	0	0	N/A	N/A	0	0	N/A	N/A	0	0	37
38	LINCOLN NATIONAL LIFE INS CO	UN	UN	UN	0	UN	UN	UN	UN	155	184	234	59	38
39	MAMSI LIFE AND HEALTH INS CO	N/A	N/A	N/A	UN	N/A	N/A	N/A	UN	N/A	N/A	N/A	UN	39
40	MANUFACTURERS LIFE INS CO	N/A	0	0	N/A	N/A	31	0	N/A	N/A	31	0	N/A	40
41	MAXICARE NORTH CAROLINA, INC	0	0	0	N/A	0	0	0	N/A	0	0	0	N/A	41
42	METRAHEALTH INS CO	N/A	N/A	N/A	0	N/A	N/A	N/A	0	N/A	N/A	N/A	0	42
43	METROPOLITAN LIFE INS CO	26	25	55	0	13	2	13	0	39	27	68	0	43
44	MID-SOUTH INS CO	3	3	72	76	12	419	107	127	15	422	179	203	44
45	MONUMENTAL LIFE INS CO	0	UN	3	0	208	UN	1	0	208	21	4	0	45

Small Group Activity Report Summary
1992 through 1995
Number of Groups Issued - All Health Benefit Plans
3-25 Market

Exhibit F

Row #	COMPANY NAME	YEAR 92 # NOT PREV INS	YEAR 93 # NOT PREV INS	YEAR 94 # NOT PREV INS	YEAR 95 # NOT PREV INS	YEAR 92 # PREV INSURED	YEAR 93 # PREV INSURED	YEAR 94 # PREV INSURED	YEAR 95 # PREV INSURED	YEAR 92 # GROUPS ISSUED	YEAR 93 # GROUPS ISSUED	YEAR 94 # GROUPS ISSUED	YEAR 95 # GROUPS ISSUED	Row #
46	NATIONAL AMERICAN LIFE INS CO OF PA	UN	0	N/A	N/A	0	27	N/A	N/A	2	27	N/A	N/A	48
47	NATIONAL FOUNDATION LIFE INS CO	0	0	N/A	N/A	0	0	N/A	N/A	0	0	N/A	N/A	47
48	NATIONAL GROUP LIFE INS CO	0	0	UN	UN	0	79	UN	UN	0	79	112	188	48
49	NATIONAL HEALTH LIFE INS CO	UN	0	0	0	UN	0	0	0	7	0	0	0	49
50	NATIONWIDE LIFE INS CO	46	121	113	UN	4	37	47	UN	50	158	160	73	50
51	NEW ENGLAND MUTUAL LIFE INS CO	44	51	7	116	63	45	10	175	107	98	17	291	51
52	NEW YORK LIFE INS CO	53	69	27	32	39	55	54	38	92	124	81	70	52
53	OPTIMUM CHOICE OF THE CAROLINAS, INC	N/A	N/A	N/A	0	N/A	N/A	N/A	0	N/A	N/A	N/A	0	53
54	PACIFIC MUTUAL LIFE INS CO	5	10	UN	10	11	18	UN	9	16	28	18	19	54
55	PAN AMERICAN LIFE INS CO	20	47	24	0	6	39	10	0	28	86	34	0	55
56	PARTNERS NATIONAL HEALTH PLAN OF NC	2	8	15	30	13	12	16	129	15	20	31	159	58
57	PFL LIFE INS CO	N/A	N/A	N/A	3	N/A	N/A	N/A	24	N/A	N/A	N/A	27	57
58	PHOENIX AMERICAN LIFE INS CO	2	0	0	0	2	0	0	0	4	0	0	0	58
59	PHOENIX HOME LIFE MUTUAL INS CO	N/A	N/A	0	0	N/A	N/A	1	0	N/A	N/A	1	0	59
60	PHP, INC	1	UN	UN	UN	22	UN	UN	UN	23	158	301	343	80
61	PIONEER LIFE INS CO OF ILLINOIS	0	0	UN	0	0	0	UN	UN	0	0	5	15	81
62	PRINCIPAL HEALTH CARE OF THE CAROLINAS	N/A	N/A	N/A	UN	N/A	N/A	N/A	UN	N/A	N/A	N/A	UN	62
63	PRINCIPAL MUTUAL LIFE INS CO	358	611	1,122	432	581	687	483	173	939	1,298	1,805	605	83
64	PROTECTIVE LIFE INS CO	52	15	13	13	51	16	28	24	103	31	41	37	84
65	PROVIDENT HEALTH CARE PLAN INC OF NC	N/A	N/A	N/A	0	N/A	N/A	N/A	0	N/A	N/A	N/A	0	85
66	PROVIDENT LIFE & ACCIDENT INS CO	N/A	N/A	32	55	N/A	N/A	44	71	N/A	N/A	76	126	66
67	PRUDENTIAL HEALTH CARE PLAN INC	UN	UN	UN	13	UN	UN	UN	22	UN	UN	UN	35	87
68	PRUDENTIAL INS CO OF AMERICA	84	56	44	24	49	45	95	27	133	101	139	51	68
69	SAVERS LIFE INS CO	0	0	N/A	N/A	0	0	N/A	N/A	0	0	N/A	N/A	89
70	SECURITY LIFE INS CO OF AMERICA	N/A	N/A	N/A	0	N/A	N/A	N/A	0	N/A	N/A	N/A	1	70
71	SENTRY LIFE INS CO	5	2	1	6	3	3	1	3	8	5	2	9	71
72	TIME INS CO	20	18	22	6	43	32	38	24	63	50	60	30	72
73	TMG LIFE INS CO	125	45	UN	23	89	194	UN	193	214	239	126	218	73
74	TRAVELERS INS CO	0	158	114	89	685	1,024	592	363	685	1,180	708	452	74
75	TRUSTMARK INSURANCE CO	2	11	16	83	51	60	58	250	53	71	74	333	75
78	UNITED OF OMAHA INS CO	UN	57	50	75	UN	36	47	73	UN	93	97	148	78
77	UNITED STATES LIFE INS CO	3	0	0	0	0	14	0	0	3	14	0	0	77
78	UNITED WISCONSIN LIFE INS CO	N/A	N/A	3	0	N/A	N/A	53	201	N/A	N/A	58	201	78
79	UNITED WORLD LIFE INS CO	UN	5	3	13	0	2	2	13	11	7	5	28	79
80	US HEALTHCARE OF THE CAROLINAS, INC	N/A	N/A	N/A	0	N/A	N/A	N/A	0	N/A	N/A	N/A	0	80
81	WELLPATH COMMUNITY HEALTH PLANS INC	N/A	N/A	N/A	0	N/A	N/A	N/A	0	N/A	N/A	N/A	0	81
82	WESTERN FIDELITY INS CO	3	7	2	N/A	8	7	3	N/A	11	14	5	N/A	82
	TOTAL	2,042	2,438	2,924	2,108	3,369	4,308	2,696	3,335	5,860	7,253	8,652	8,793	

COLUMN AND ROW TOTALS MAY NOT ADD CORRECTLY DUE TO SOME CARRIERS' INABILITY TO PROVIDE THE DATA IN THE DETAIL REQUIRED

UN = UNKNOWN

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COMPANY NAME IN BOLD INDICATES A RISK ASSUMING CARRIER

NATIONWIDE LIFE INS CO INCLUDES EMPLOYERS LIFE INS CO OF WAUSAU

FIRST ALLMERICA FINANCIAL LIFE INS CO WAS FORMERLY STATE MUTUAL LIFE ASSUR CO OF AMERICA

1992 through 1995
Total Number of Groups Inforce as of December 31st
3-25 Market

Row #	COMPANY NAME	YEAR 92 BASIC	YEAR 93 BASIC	YEAR 94 BASIC	YEAR 95 BASIC	YEAR 92 STD	YEAR 93 STD	YEAR 94 STD	YEAR 95 STD	YEAR 92 TRAD	YEAR 93 TRAD	YEAR 94 TRAD	YEAR 95 TRAD	YEAR 92 ALL PLANS	YEAR 93 ALL PLANS	YEAR 94 ALL PLANS	YEAR 95 ALL PLANS	Row #
1	AETNA HEALTH PLANS OF THE CAROLINAS, INC	N/A	N/A	N/A	0	N/A	N/A	N/A	0	N/A	N/A	N/A	0	N/A	N/A	N/A	0	1
2	AETNA LIFE INS CO	0	0	0	0	0	0	0	0	100	83	86	67	100	83	88	87	2
3	ALLIANZ LIFE INS CO OF NORTH AMERICA	N/A	N/A	0	0	N/A	N/A	0	0	N/A	N/A	0	3	N/A	N/A	0	3	3
4	AMERICAN FIDELITY ASSUR CO	N/A	0	0	NR	N/A	0	1	NR	N/A	7	34	NR	N/A	7	35	0	4
5	AMERICAN NATIONAL LIFE INS CO	0	0	0	0	0	0	0	0	13	11	7	34	13	11	7	34	5
6	AMERICAN SERVICE LIFE INS CO	0	0	0	N/A	0	0	0	N/A	125	0	0	N/A	125	0	0	0	8
7	BANKERS UNITED LIFE ASSUR CO	N/A	N/A	N/A	0	N/A	N/A	N/A	0	N/A	N/A	N/A	1	N/A	N/A	N/A	1	7
8	BLUE CROSS BLUE SHIELD/NC	6	4	1	0	15	69	102	121	8,302	8,376	6,610	7,343	8,323	8,449	8,813	7,484	8
9	BOSTON MUTUAL LIFE INS CO	0	0	0	0	0	0	0	0	98	148	52	15	98	148	52	15	9
10	CELTIC LIFE INS CO	0	0	0	NR	0	1	0	NR	71	70	46	NR	71	71	48	0	10
11	CENTENNIAL LIFE INS CO	0	0	0	0	0	1	1	0	386	169	88	85	386	170	87	85	11
12	CENTRAL RESERVE LIFE INS CO	0	0	0	0	1	10	4	1	318	386	416	477	319	398	420	478	12
13	CIGNA HEALTHCARE OF NORTH CAROLINA	N/A	N/A	0	0	N/A	N/A	38	53	N/A	N/A	12	31	N/A	N/A	50	84	13
14	COLONIAL LIFE INS CO OF AMERICA	0	0	0	0	0	3	1	0	113	168	66	19	113	171	67	19	14
15	CONNECTICUT GENERAL LIFE INS CO	0	0	0	0	0	0	0	0	6	3	6	4	8	3	6	4	15
16	CUNA MUTUAL INSURANCE SOCIETY	0	0	0	0	0	0	0	0	44	43	43	48	44	43	43	48	18
17	DOCTORS HEALTH PLAN, INC	N/A	N/A	N/A	0	N/A	N/A	N/A	0	N/A	N/A	N/A	4	N/A	N/A	N/A	4	17
18	DURHAM LIFE INS CO	0	0	N/A	N/A	1	0	N/A	N/A	631	0	N/A	N/A	632	0	N/A	N/A	18
19	EMPLOYERS HEALTH INS CO	UN	UN	UN	1	UN	UN	UN	23	UN	UN	UN	678	UN	UN	UN	702	19
20	EMPLOYERS LIFE INS CO OF WAUSAU	N/A	N/A	N/A	UN	N/A	N/A	N/A	UN	N/A	N/A	N/A	UN	N/A	N/A	N/A	UN	20
21	FEDERATED MUTUAL INS CO	0	0	0	0	1	2	2	2	252	226	252	169	253	228	254	171	21
22	FIRST ALLMERICA FINANCIAL LIFE INS CO	0	0	0	0	0	0	0	0	9	7	2	0	9	7	2	0	22
23	FORTIS BENEFITS INS CO	0	0	0	0	3	8	4	4	384	196	379	555	387	204	383	559	23
24	FRANKLIN LIFE INS CO	N/A	0	0	0	N/A	0	0	2	N/A	2	9	23	N/A	2	9	25	24
25	GENERAL AMERICAN LIFE INS CO	N/A	N/A	N/A	0	N/A	N/A	N/A	7	N/A	N/A	N/A	16	N/A	N/A	N/A	23	25
26	GREAT-WEST LIFE & ANNUITY INS CO	N/A	N/A	0	0	N/A	N/A	0	0	N/A	N/A	0	10	N/A	N/A	0	10	28
27	GUARDIAN LIFE INS CO	0	0	0	0	1	1	0	1	725	646	668	556	728	847	868	557	27
28	HEALTHSOURCE, NORTH CAROLINA	N/A	N/A	0	0	N/A	N/A	2	15	N/A	N/A	12	53	N/A	N/A	14	68	28
29	HOME LIFE FINANCIAL ASSURANCE CORP	0	0	0	0	0	5	4	5	216	118	159	155	218	123	163	160	29
30	INDEPENDENT LIFE AND ACCIDENT INS CO	0	0	N/A	N/A	0	0	N/A	N/A	88	83	N/A	N/A	88	83	N/A	N/A	30
31	JEFFERSON-PILOT LIFE INS CO	0	0	0	0	1	2	1	0	93	82	85	89	94	84	88	89	31
32	JOHN ALDEN LIFE INS CO	0	0	0	0	10	52	43	71	3,277	3,462	3,797	3,636	3,287	3,514	3,840	3,707	32
33	JOHN HANCOCK MUTUAL LIFE INS CO	0	0	0	0	0	0	0	0	167	112	120	100	167	112	120	100	33
34	KAISER FOUNDATION HEALTH PLAN/NC	0	0	0	0	0	1	0	28	274	299	282	530	274	300	282	558	34
35	KANAWHA INS CO	0	0	0	0	0	7	5	1	104	80	77	105	104	87	82	108	35
36	LAMAR LIFE INS CO	0	0	0	0	0	0	0	0	20	14	7	4	20	14	7	4	38
37	LIFE INVESTORS INSURANCE CO OF AMER	N/A	N/A	0	0	N/A	N/A	0	0	N/A	N/A	3	5	N/A	N/A	3	5	37
38	LINCOLN NATIONAL LIFE INS CO	1	0	0	0	5	11	23	5	633	685	815	231	639	696	838	238	38
39	MAMSI LIFE AND HEALTH INS CO	N/A	N/A	N/A	UN	N/A	N/A	N/A	UN	N/A	N/A	N/A	UN	N/A	N/A	N/A	UN	39
40	MANUFACTURERS LIFE INS CO	N/A	0	0	N/A	N/A	1	2	N/A	N/A	30	2	N/A	N/A	31	4	N/A	40
41	MAXICARE NORTH CAROLINA, INC	0	0	0	N/A	0	0	0	N/A	3	0	0	N/A	3	0	0	N/A	41
42	METRAHEALTH INS CO	N/A	N/A	N/A	0	N/A	N/A	N/A	0	N/A	N/A	N/A	0	N/A	N/A	N/A	0	42
43	METROPOLITAN LIFE INS CO	0	0	0	0	0	0	1	1	116	276	67	36	118	276	68	37	43
44	MID-SOUTH INS CO	0	1	1	0	0	1	8	11	186	627	624	664	186	629	633	875	44
45	MONUMENTAL LIFE INS CO	0	0	0	0	0	0	0	0	209	475	139	101	209	475	139	101	45

1992 through 1995
Total Number of Groups Inforce as of December 31st
3-25 Market

Row #	COMPANY NAME	YEAR 92 BASIC	YEAR 93 BASIC	YEAR 94 BASIC	YEAR 95 BASIC	YEAR 92 STD	YEAR 93 STD	YEAR 94 STD	YEAR 95 STD	YEAR 92 TRAD	YEAR 93 TRAD	YEAR 94 TRAD	YEAR 95 TRAD	YEAR 92 ALL PLANS	YEAR 93 ALL PLANS	YEAR 94 ALL PLANS	YEAR 95 ALL PLANS	Row #
48	NATIONAL AMERICAN LIFE INS CO OF PA	0	0	N/A	N/A	0	0	N/A	N/A	15	27	N/A	N/A	15	27	N/A	N/A	48
47	NATIONAL FOUNDATION LIFE INS CO	0	0	N/A	N/A	0	0	N/A	N/A	0	0	N/A	N/A	0	0	N/A	N/A	47
48	NATIONAL GROUP LIFE INS CO	0	0	0	1	0	0	0	4	0	86	180	301	0	86	180	308	48
49	NATIONAL HEALTH LIFE INS CO	0	0	0	0	0	0	0	0	24	13	9	8	24	13	9	8	49
50	NATIONWIDE LIFE INS CO	0	1	3	4	0	3	3	0	476	546	626	377	476	550	632	381	50
51	NEW ENGLAND MUTUAL LIFE INS CO	0	0	4	0	0	1	0	2	217	299	178	288	217	300	180	270	51
52	NEW YORK LIFE INS CO	2	1	0	0	7	22	13	15	325	326	274	326	334	349	287	341	52
53	OPTIMUM CHOICE OF THE CAROLINAS, INC	N/A	N/A	N/A	0	N/A	N/A	N/A	0	N/A	N/A	N/A	0	N/A	N/A	N/A	0	63
54	PACIFIC MUTUAL LIFE INS CO	0	0	0	0	0	0	0	0	50	72	54	86	50	72	54	68	54
55	PAN AMERICAN LIFE INS CO	0	0	0	0	0	6	6	5	167	233	150	150	187	239	156	155	55
58	PARTNERS NATIONAL HEALTH PLAN OF NC	1	5	9	30	3	5	16	46	51	22	58	83	55	32	83	159	58
57	PFL LIFE INS CO	N/A	N/A	N/A	0	N/A	N/A	N/A	0	N/A	N/A	N/A	36	N/A	N/A	N/A	38	67
58	PHOENIX AMERICAN LIFE INS CO	0	0	0	0	0	0	0	0	29	29	0	1	29	29	0	1	58
59	PHOENIX HOME LIFE MUTUAL INS CO	N/A	N/A	0	0	N/A	N/A	0	0	N/A	N/A	9	7	N/A	N/A	9	7	59
60	PHP, INC	0	UN	0	1	0	UN	1	12	23	158	457	718	23	158	458	731	80
61	PIONEER LIFE INS CO OF ILLINOIS	0	0	0	0	0	0	0	2	0	417	311	101	0	417	311	103	61
62	PRINCIPAL HEALTH CARE OF THE CAROLINAS	N/A	N/A	N/A	UN	N/A	N/A	N/A	UN	N/A	N/A	N/A	UN	N/A	N/A	N/A	0	82
63	PRINCIPAL MUTUAL LIFE INS CO	0	1	1	1	18	37	86	104	2,174	3,606	4,508	4,244	2,192	3,644	4,695	4,349	63
64	PROTECTIVE LIFE INS CO	0	0	1	0	1	10	17	10	273	194	306	183	274	204	324	193	64
65	PROVIDENT HEALTH CARE PLAN INC OF NC	N/A	N/A	N/A	0	N/A	N/A	N/A	0	N/A	N/A	N/A	0	N/A	N/A	N/A	0	85
66	PROVIDENT LIFE & ACCIDENT INS CO	N/A	N/A	0	0	N/A	N/A	2	5	N/A	N/A	81	165	N/A	N/A	83	170	88
67	PRUDENTIAL HEALTH CARE PLAN INC	UN	UN	UN	1	UN	UN	UN	11	UN	UN	UN	27	UN	UN	UN	39	67
68	PRUDENTIAL INS CO OF AMERICA	0	0	0	0	0	0	1	2	803	699	598	495	803	699	599	497	88
69	SAVERS LIFE INS CO	0	0	N/A	N/A	0	0	N/A	N/A	0	0	N/A	N/A	0	0	N/A	N/A	69
70	SECURITY LIFE INS CO OF AMERICA	N/A	N/A	N/A	0	N/A	N/A	N/A	0	N/A	N/A	N/A	5	N/A	N/A	N/A	6	70
71	SENTRY LIFE INS CO	0	0	0	0	0	0	0	0	68	47	30	29	88	47	30	29	71
72	TIME INS CO	0	0	0	0	0	2	2	1	247	217	288	238	247	219	290	239	72
73	TMG LIFE INS CO	0	0	0	0	2	5	4	8	589	713	492	578	591	718	498	584	73
74	TRAVELERS INS CO	0	0	0	0	0	0	8	24	1,024	1,180	1,524	1,617	1,024	1,180	1,532	1,841	74
75	TRUSTMARK INSURANCE CO	0	0	0	0	0	2	6	14	123	167	185	504	123	169	190	518	75
76	UNITED OF OMAHA INS CO	0	0	1	0	3	3	2	7	UN	336	307	366	3	339	310	373	78
77	UNITED STATES LIFE INS CO	0	0	0	0	0	1	0	0	9	13	12	7	9	14	12	7	77
78	UNITED WISCONSIN LIFE INS CO	N/A	N/A	0	0	N/A	N/A	0	2	N/A	N/A	8	199	N/A	N/A	8	201	78
79	UNITED WORLD LIFE INS CO	0	0	0	0	0	0	0	0	11	10	14	33	11	10	14	33	79
80	US HEALTHCARE OF THE CAROLINAS, INC	N/A	N/A	N/A	0	N/A	N/A	N/A	0	N/A	N/A	N/A	0	N/A	N/A	N/A	0	80
81	WELLPATH COMMUNITY HEALTH PLANS INC	N/A	N/A	N/A	0	N/A	N/A	N/A	0	N/A	N/A	N/A	0	N/A	N/A	N/A	0	81
82	WESTERN FIDELITY INS CO	0	0	0	N/A	0	0	1	N/A	13	18	5	N/A	13	18	8	N/A	82
	TOTAL	10	13	21	39	72	272	409	623	23,672	26,312	25,525	26,977	23,754	28,597	25,955	27,839	

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COMPANY NAME IN BOLD INDICATES A RISK ASSUMING CARRIER

NATIONWIDE LIFE INS CO INCLUDES EMPLOYERS LIFE INS CO OF WAUSAU

FIRST ALLMERICA FINANCIAL LIFE INS CO WAS FORMERLY STATE MUTUAL LIFE ASSUR CO OF AMERICA

D-23

1992 through 1995

Total Number of Employees Covered as of Decemberr 31st

3-25 Market

Row #	COMPANY NAME	YEAR 92 BASIC	YEAR 93 BASIC	YEAR 94 BASIC	YEAR 95 BASIC	YEAR 92 STD	YEAR 93 STD	YEAR 94 STD	YEAR 95 STD	YEAR 92 TRAD	YEAR 93 TRAD	YEAR 94 TRAD	YEAR 95 TRAD	YEAR 92 ALL PLANS	YEAR 93 ALL PLANS	YEAR 94 ALL PLANS	YEAR 95 ALL PLANS	Row #
1	AETNA HEALTH PLANS OF THE CARDLINAS, INC	N/A	N/A	N/A	0	N/A	N/A	N/A	0	N/A	N/A	N/A	0	N/A	N/A	N/A	0	1
2	AETNA LIFE INS CO	0	0	0	0	0	0	0	0	1,369	1,092	1,100	963	1,369	1,092	1,100	983	2
3	ALLIANZ LIFE INS CO OF NORTH AMERICA	N/A	N/A	0	0	N/A	N/A	0	0	N/A	N/A	0	7	N/A	N/A	0	7	3
4	AMERICAN FIDELITY ASSUR CO	N/A	0	0	NR	N/A	0	4	NR	N/A	200	244	NR	N/A	200	248	0	4
5	AMERICAN NATIONAL LIFE INS CO	0	0	0	0	0	0	0	0	206	100	37	256	206	100	37	258	6
6	AMERICAN SERVICE LIFE INS CO	0	0	0	N/A	0	0	0	N/A	315	0	0	N/A	315	0	0	N/A	6
7	BANKERS UNITED LIFE ASSUR CO	N/A	N/A	N/A	0	N/A	N/A	N/A	0	N/A	N/A	N/A	7	N/A	N/A	N/A	7	7
8	BLUE CROSS BLUE SHIELD/NC	35	17	10	0	78	385	668	646	65,141	63,834	58,315	57,398	65,254	64,236	58,993	68,042	8
9	BOSTON MUTUAL LIFE INS CO	0	0	0	0	0	0	0	0	520	643	300	99	620	643	300	99	9
10	CELTIC LIFE INS CO	0	0	0	NR	0	7	0	NR	359	316	220	NR	359	323	220	0	10
11	CENTENNIAL LIFE INS CO	0	0	0	0	0	6	7	0	2,823	1,193	634	593	2,823	1,199	841	593	11
12	CENTRAL RESERVE LIFE INS CO	0	0	0	0	4	31	13	3	1,942	2,346	2,466	3,014	1,948	2,377	2,479	3,017	12
13	CIGNA HEALTHCARE OF NORTH CAROLINA	N/A	N/A	0	0	N/A	N/A	555	328	N/A	N/A	154	478	N/A	N/A	709	808	13
14	COLONIAL LIFE INS CO OF AMERICA	0	0	0	0	0	12	3	0	1,376	2,392	627	260	1,376	2,404	630	280	14
15	CONNECTICUT GENERAL LIFE INS CO	0	0	0	0	0	0	0	0	71	34	90	38	71	34	90	38	16
16	CUNA MUTUAL INSURANCE SOCIETY	0	0	0	0	0	0	0	0	302	337	298	409	302	337	298	409	18
17	DOCTORS HEALTH PLAN, INC	N/A	N/A	N/A	0	N/A	N/A	N/A	0	N/A	N/A	N/A	19	N/A	N/A	N/A	19	17
18	DURHAM LIFE INS CO	0	0	N/A	N/A	4	0	N/A	N/A	3,490	0	N/A	N/A	3,494	0	N/A	N/A	18
19	EMPLOYERS HEALTH INS CO	UN	UN	UN	3	UN	UN	UN	108	UN	UN	UN	4,551	UN	UN	UN	4,652	19
20	EMPLOYERS LIFE INS CO OF WAUSAU	N/A	N/A	N/A	UN	N/A	N/A	N/A	UN	N/A	N/A	N/A	UN	N/A	N/A	N/A	UN	20
21	FEDERATED MUTUAL INS CO	0	0	0	0	7	19	21	13	2,192	2,113	1,919	1,075	2,199	2,132	1,940	1,088	21
22	FIRST ALLMERICA FINANCIAL LIFE INS CO	0	0	0	0	0	0	0	0	1,500	176	43	0	1,500	176	43	0	22
23	FORTIS BENEFITS INS CO	0	0	0	0	31	43	37	27	2,947	1,354	3,022	4,449	2,978	1,397	3,059	4,476	23
24	FRANKLIN LIFE INS CO	N/A	0	0	0	N/A	0	0	14	N/A	8	9	148	N/A	8	9	162	24
25	GENERAL AMERICAN LIFE INS CO	N/A	N/A	N/A	0	N/A	N/A	N/A	86	N/A	N/A	N/A	104	N/A	N/A	N/A	190	25
26	GREAT-WEST LIFE & ANNUITY INS CO	N/A	N/A	0	0	N/A	N/A	0	0	N/A	N/A	0	235	N/A	N/A	0	235	28
27	GUARDIAN LIFE INS CO	0	0	0	0	2	2	0	5	6,100	5,660	5,844	4,859	6,102	5,662	6,844	4,864	27
28	HEALTHSOURCE, NORTH CAROLINA	N/A	N/A	0	0	N/A	N/A	20	98	N/A	N/A	101	355	N/A	N/A	121	453	28
29	HOME LIFE FINANCIAL ASSURANCE CORP	0	0	0	0	0	44	31	30	1,509	692	568	1,006	1,509	736	599	1,038	29
30	INDEPENDENT LIFE AND ACCIDENT INS CO	0	0	N/A	N/A	0	0	N/A	N/A	561	582	N/A	N/A	681	582	N/A	N/A	30
31	JEFFERSON-PILOT LIFE INS CO	0	0	0	0	6	10	5	0	1,484	1,228	1,401	1,418	1,490	1,238	1,406	1,416	31
32	JOHN ALDEN LIFE INS CO	0	0	0	0	55	262	197	347	19,497	20,199	23,082	22,416	19,552	20,461	23,279	22,752	32
33	JOHN HANCOCK MUTUAL LIFE INS CO	0	0	0	0	0	0	0	0	1,005	670	588	628	1,005	870	688	825	33
34	KAISER FOUNDATION HEALTH PLAN/NC	0	0	0	0	0	3	0	60	3,459	3,846	2,220	2,983	3,459	3,849	2,220	3,043	34
35	KANAWHA INS CO	0	0	0	0	0	63	24	4	640	765	620	792	840	818	644	798	35
36	LAMAR LIFE INS CO	0	0	0	0	0	0	0	0	136	98	57	29	136	96	57	29	38
37	LIFE INVESTORS INSURANCE CO OF AMER	N/A	N/A	0	0	N/A	N/A	0	0	N/A	N/A	14	18	N/A	N/A	14	18	37
38	LINCOLN NATIONAL LIFE INS CO	5	0	0	0	18	46	83	21	5,440	5,639	5,887	1,182	5,483	5,685	6,970	1,203	38
39	MAMSI LIFE AND HEALTH INS CO	N/A	N/A	N/A		N/A	N/A	N/A	UN	N/A	N/A	N/A	UN	N/A	N/A	N/A	UN	39
40	MANUFACTURERS LIFE INS CO	N/A	0	0	N/A	N/A	4	8	N/A	N/A	286	8	N/A	N/A	290	18	N/A	40
41	MAXICARE NORTH CAROLINA, INC	0	0	0	N/A	0	0	0	N/A	39	0	0	N/A	39	0	0	N/A	41
42	METRAHEALTH INS CO	N/A	N/A	N/A	0	N/A	N/A	N/A	0	N/A	N/A	N/A	0	N/A	N/A	N/A	0	42
43	METROPOLITAN LIFE INS CO	0	0	0	0	0	0	9	10	646	723	331	201	648	723	340	211	43
44	MID-SOUTH INS CO	0	3	6	0	0	7	25	51	1,723	5,077	6,037	5,592	1,723	5,087	6,088	5,643	44
45	MONUMENTAL LIFE INS CO	0	0	0	0	0	0	0	0	1,321	0	747	487	1,321	0	747	487	45

1992 through 1995
Total Number of Employees Covered as of December 31st
3-25 Market

Row #	COMPANY NAME	YEAR 92 BASIC	YEAR 93 BASIC	YEAR 94 BASIC	YEAR 95 BASIC	YEAR 92 STD	YEAR 93 STD	YEAR 94 STD	YEAR 95 STD	YEAR 92 TRAD	YEAR 93 TRAD	YEAR 94 TRAD	YEAR 95 TRAD	YEAR 92 ALL PLANS	YEAR 93 ALL PLANS	YEAR 94 ALL PLANS	YEAR 95 ALL PLANS	Row #
46	NATIONAL AMERICAN LIFE INS CO OF PA	0	0	N/A	N/A	0	0	N/A	N/A	143	262	N/A	N/A	143	282	N/A	N/A	46
47	NATIONAL FOUNDATION LIFE INS CO	0	0	N/A	N/A	0	0	N/A	N/A	0	0	N/A	N/A	0	0	N/A	N/A	47
48	NATIONAL GROUP LIFE INS CO	0	0	0	3	0	0	0	20	0	343	723	1,263	0	343	723	1,288	48
49	NATIONAL HEALTH LIFE INS CO	0	0	0	0	0	0	0	0	86	42	29	18	88	42	29	18	49
50	NATIONWIDE LIFE INS CO	0	2	7	14	0	12	8	0	2,056	2,221	2,833	2,517	2,056	2,235	2,848	2,531	50
51	NEW ENGLAND MUTUAL LIFE INS CO	0	0	16	0	0	3	0	7	1,496	1,536	1,115	1,803	1,496	1,539	1,131	1,810	51
52	NEW YORK LIFE INS CO	9	4	0	0	25	90	57	62	2,638	2,509	2,112	1,986	2,872	2,803	2,189	2,028	52
53	OPTIMUM CHOICE OF THE CAROLINAS, INC	N/A	N/A	N/A	0	N/A	N/A	N/A	0	N/A	N/A	N/A	0	N/A	N/A	N/A	0	53
54	PACIFIC MUTUAL LIFE INS CO	0	0	0	0	0	0	0	0	390	869	541	673	390	869	541	573	54
55	PAN AMERICAN LIFE INS CO	0	0	0	0	0	41	34	25	981	1,352	923	770	981	1,393	957	795	55
56	PARTNERS NATIONAL HEALTH PLAN OF NC	7	18	39	155	11	17	103	324	734	275	810	844	752	310	952	1,323	56
57	PFL LIFE INS CO	N/A	N/A	N/A	0	N/A	N/A	N/A	0	N/A	N/A	N/A	88	N/A	N/A	N/A	88	57
58	PHOENIX AMERICAN LIFE INS CO	0	0	0	0	0	0	0	0	253	253	0	24	253	253	0	24	58
59	PHOENIX HOME LIFE MUTUAL INS CO	N/A	N/A	0	0	N/A	N/A	0	0	N/A	N/A	78	78	N/A	N/A	78	78	59
60	PHP, INC	0	UN	0	5	0	UN	25	59	171	1,133	3,571	4,778	171	1,133	3,598	4,842	60
61	PIONEER LIFE INS CO OF ILLINOIS	0	0	0	0	0	0	0	6	0	1,942	311	521	0	1,942	311	529	61
62	PRINCIPAL HEALTH CARE OF THE CAROLINAS	N/A	N/A	N/A	UN	N/A	N/A	N/A	UN	N/A	N/A	N/A	UN	N/A	N/A	N/A	UN	62
63	PRINCIPAL MUTUAL LIFE INS CO	0	3	4	3	111	125	598	656	9,189	26,557	36,344	31,954	9,300	26,685	38,946	32,813	63
64	PROTECTIVE LIFE INS CO	0	0	3	0	4	33	62	44	1,135	1,022	1,006	991	1,139	1,055	1,061	1,035	64
65	PROVIDENT HEALTH CARE PLAN INC OF NC	N/A	N/A	N/A	0	N/A	N/A	N/A	0	N/A	N/A	N/A	0	N/A	N/A	N/A	0	65
68	PROVIDENT LIFE & ACCIDENT INS CO	N/A	N/A	0	0	N/A	N/A	6	28	N/A	N/A	562	1,203	N/A	N/A	568	1,229	66
67	PRUDENTIAL HEALTH CARE PLAN INC	UN	UN	UN	11	UN	UN	UN	73	UN	UN	UN	183	UN	UN	UN	287	67
68	PRUDENTIAL INS CO OF AMERICA	0	0	0	0	0	0	3	11	6,190	4,649	3,956	3,094	6,190	4,549	3,959	3,105	68
69	SAVERS LIFE INS CO	0	0	N/A	N/A	0	0	N/A	N/A	0	0	N/A	N/A	0	0	N/A	N/A	89
70	SECURITY LIFE INS CO OF AMERICA	N/A	N/A	N/A	0	N/A	N/A	N/A	0	N/A	N/A	N/A	40	N/A	N/A	N/A	40	70
71	SENTRY LIFE INS CO	0	0	0	0	0	0	0	0	369	293	193	160	369	293	193	150	71
72	TIME INS CO	0	0	0	0	0	8	7	3	1,403	1,196	1,303	958	1,403	1,202	1,310	961	72
73	TMG LIFE INS CO	0	0	0	0	10	35	22	26	4,280	4,666	3,521	4,377	4,290	4,701	3,543	4,403	73
74	TRAVELERS INS CO	0	0	0	0	0	0	70	205	7,466	8,777	11,462	12,055	7,468	8,777	11,532	12,260	74
76	TRUSTMARK INSURANCE CO	0	0	0	0	0	9	35	120	1,445	1,715	2,020	4,781	1,445	1,724	2,055	4,901	75
76	UNITED OF OMAHA INS CO	0	0	11	0	10	15	9	28	UN	2,147	1,929	2,151	10	2,162	1,949	2,179	76
77	UNITED STATES LIFE INS CO	0	0	0	0	0	3	0	0	56	98	97	43	56	101	97	43	77
78	UNITED WISCONSIN LIFE INS CO	N/A	N/A	0	0	N/A	N/A	0	6	N/A	N/A	44	1,108	N/A	N/A	44	1,112	76
79	UNITED WORLD LIFE INS CO	0	0	0	0	0	0	0	0	51	57	69	161	51	57	69	181	79
80	US HEALTHCARE OF THE CAROLINAS, INC	N/A	N/A	N/A	0	N/A	N/A	N/A	0	N/A	N/A	N/A	0	N/A	N/A	N/A	0	80
81	WELLPATH COMMUNITY HEALTH PLANS INC	N/A	N/A	N/A	0	N/A	N/A	N/A	0	N/A	N/A	N/A	0	N/A	N/A	N/A	0	81
82	WESTERN FIDELITY INS CO	0	0	0	N/A	0	0	1	N/A	62	102	23	N/A	82	102	24	N/A	62
	TOTAL	56	47	96	194	376	1,323	2,740	3,554	167,909	185,517	191,558	194,558	168,341	188,887	194,394	198,306	

COLUMN AND ROW TOTALS MAY NOT ADD CORRECTLY DUE TO SOME CARRIERS' INABILITY TO PROVIDE THE DATA IN THE DETAIL REQUIRED

UN = UNKNOWN
N/A = NOT APPLICABLE
NR = NOT REPORTED

COMPANY NAME IN BOLD INDICATES A RISK ASSUMING CARRIER

NATIONWIDE LIFE INS CO INCLUDES EMPLOYERS LIFE INS CO OF WAUSAU
FIRST ALLMERICA FINANCIAL LIFE INS CO WAS FORMERLY STATE MUTUAL LIFE ASSUR CO OF AMERICA

Exhibit I

Small Group Activity Report Summary
1992 through 1995
Average Group Size
3-25 Market

		1992	1993	1994	1995
BASIC	# GROUPS INFORCE	10	13	21	39
	# EMPLOYEES COVERED	56	47	96	194
	AVERAGE GROUP SIZE	5.6	3.6	4.6	5.0
STANDARD	# GROUPS INFORCE	72	272	409	623
	# EMPLOYEES COVERED	376	1,323	2,740	3,554
	AVERAGE GROUP SIZE	5.2	4.9	6.7	5.7
TRADITIONAL	# GROUPS INFORCE	23,672	26,312	25,525	26,977
	# EMPLOYEES COVERED	167,909	185,517	191,558	194,558
	AVERAGE GROUP SIZE	7.1	7.1	7.5	7.2
ALL PLANS	# GROUPS INFORCE	23,754	26,597	25,955	27,639
	# EMPLOYEES COVERED	168,341	186,887	194,394	198,306
	AVERAGE GROUP SIZE	7.1	7.0	7.5	7.2

1995 Premiums and Claims for All Health Benefit Plans
(In 000's)

ROW #	COMPANY NAME	3 - 25 MARKET PREM WRITTEN	PREM EARNED	CLAIMS PAID	CLAIMS INC	INC LOSS RATIO	ONE-MAN / SELF-EMPLOYED GROUPS PREM WRITTEN	PREM EARNED	CLAIMS PAID	CLAIMS INC	INC LOSS RATIO	1 - 49 MARKET PREM WRITTEN	PREM EARNED	CLAIMS PAID	CLAIMS INC	INC LOSS RATIO	ROW #
1	AETNA HEALTH PLANS OF THE CAROLINAS, INC	$0	$0	$0	$0	0.0%	$0	$0	$0	$0	0.0%	$0	$26	$10	$0	UN	1
2	AETNA LIFE INS CO	2,494	2,494	1,827	1,941	77.8%	0	0	0	0	0.0%	6,532	8,532	5,061	5,380	82.4%	2
3	ALLIANZ LIFE INS CO OF NORTH AMERICA	10	10	8	11	0.0%	0	0	0	0	0.0%	12	12	7	12	95.8%	3
4	AMERICAN FIDELITY ASSUR CO	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR	4
5	AMERICAN NATIONAL LIFE INS CO	118	118	152	158	134.6%	5	5	1	3	60.4%	680	670	712	704	105.1%	5
6	AMERICAN SERVICE LIFE INS CO	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	6
7	BANKERS UNTIED LIFE ASSUR CO	25	24	22	17	73.3%	0	0	0	0	0.0%	25	24	22	17	73.3%	7
8	BLUE CROSS BLUE SHIELD/NC	141,016	140,953	126,055	128,745	91.3%	4,023	4,075	4,171	4,246	104.2%	200,572	200,605	178,718	183,975	91.7%	8
9	BOSTON MUTUAL LIFE INS CO	479	487	2	2	0.3%	2	2	0	0	0.0%	$57	567	13	10	1.8%	9
10	CELTIC LIFE INSURANCE COMPANY	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR	NR	10
11	CENTENNIAL LIFE INS CO	1,318	1,310	867	778	59.4%	35	34	14	15	43.6%	1,629	1,810	1,040	953	59.2%	11
12	CENTRAL RESERVE LIFE INS CO	UN	4,701	323	UN	UN	UN	0	0	UN	0.0%	UN	6,136	4,373	UN	UN	12
13	CIGNA HEALTHCARE OF NORTH CAROLINA	UN	UN	UN	UN	UN	UN	UN	UN	UN	UN	UN	UN	UN	UN	UN	13
14	COLONIAL LIFE INS CO OF AMERICA	1,074	1,042	850	762	73.2%	0	0	0	0	0.0%	1,460	1,416	1,034	985	69.6%	14
15	CONNECTICUT GENERAL LIFE INS CO	219	219	78	78	35.7%	0	0	0	0	0.0%	219	219	78	78	35.7%	15
16	CUNA MUTUAL INSURANCE SOCIETY	1,198	1,193	909	888	74.4%	0	0	0	0	0.0%	1,593	1,590	1,251	1,222	78.9%	16
17	DOCTORS HEALTH PLAN, INC	7	7	2	2	30.5%	4	4	2	2	45.2%	35	35	8	8	23.4%	17
18	DURHAM LIFE INS CO	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	18
19	EMPLOYERS HEALTH INS CO	10,513	10,496	7,930	8,264	78.7%	0	0	0	0	0.0%	14,963	15,019	11,551	12,070	80.4%	19
20	EMPLOYERS LIFE INS CO OF WAUSAU	UN	UN	UN	UN	UN	UN	UN	UN	UN	UN	UN	UN	UN	UN	UN	20
21	FEDERATED MUTUAL INS CO	33,303	3,303	2,600	2,600	78.7%	0	0	0	0	0.0%	4,224	4,224	3,406	3,406	80.6%	21
22	FIRST ALLMERICA FINANCIAL LIFE INS CO	66	66	40	15	23.0%	0	0	0	0	0.0%	717	717	434	422	58.9%	22
23	FORTIS BENEFITS INS CO	9,141	9,244	6,514	6,860	74.2%	306	309	261	275	89.0%	13,015	13,162	9,383	9,880	75.1%	23
24	FRANKLIN LIFE INS CO	262	262	39	45	17.2%	28	26	4	4	14.7%	201	201	75	85	42.0%	24
25	GENERAL AMERICAN LIFE INS CO	471	484	446	527	109.0%	0	0	0	0	0.0%	872	713	565	577	81.0%	25
26	GREAT-WEST LIFE & ANNUITY INS CO	248	248	162	203	81.9%	0	0	0	0	0.0%	1,423	1,423	1,790	2,066	0.0%	26
27	GUARDIAN LIFE INS CO	13,537	13,589	9,582	9,650	71.0%	338	339	278	280	82.6%	22,021	22,107	17,585	17,710	80.1%	27
28	HEALTHSOURCE, NORTH CAROLINA	UN	UN	UN	UN	UN	UN	UN	UN	UN	UN	UN	UN	UN	UN	UN	28
29	HOME LIFE FINANCIAL ASSURANCE CORP	2,738	2,738	2,618	2,386	87.1%	160	160	220	163	101.7%	3,821	3,821	3,839	3,418	89.4%	29
30	INDEPENDENT LIFE AND ACCIDENT INS CO	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	30
31	JEFFERSON-PILOT LIFE INS CO	3,186	3,200	2,439	2,500	78.1%	0	0	0	0	0.0%	10,483	10,500	8,448	8,500	81.0%	31
32	JOHN ALDEN LIFE INS CO	46,640	46,730	38,648	39,968	85.5%	0	0	0	0	UN	60,274	60,391	50,558	52,284	86.6%	32
33	JOHN HANCOCK MUTUAL LIFE INS CO	2,192	2,192	1,490	1,490	68.0%	728	728	517	517	71.0%	3,735	3,735	3,190	3,190	85.4%	33
34	KAISER FOUNDATION HEALTH PLAN/NC	13,293	13,293	UN	UN	UN	127	127	UN	UN	UN	17,439	17,439	UN	UN	UN	34
35	KANAWHA INS CO	1,447	1,447	977	901	62.2%	72	72	216	36	50.1%	2,227	2,227	617	606	27.2%	35
36	LAMAR LIFE INS CO	UN	90	31	20	22.1%	UN	0	0	0	0.0%	UN	90	31	20	22.1%	36
37	LIFE INVESTORS INSURANCE CO OF AMER	47	50	20	20	40.1%	0	0	0	0	0.0%	372	375	283	279	74.5%	37
38	LINCOLN NATIONAL LIFE INS CO	3,230	3,224	2,589	2,555	79.2%	0	0	0	0	0.0%	4,718	4,699	3,720	3,726	79.3%	38
39	MAMSI LIFE AND HEALTH INS CO	UN	UN	UN	UN	UN	UN	UN	UN	UN	UN	UN	UN	UN	UN	#DIV/0!	39
40	MANUFACTURERS LIFE INS CO	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	40
41	MAXICARE NORTH CAROLINA, INC	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	41
42	METRAHEALTH INS CO	0	0	0	0	0.0%	0	0	0	0	0.0%	0	0	0	0	0.0%	42
43	METROPOLITAN LIFE INS CO	655	634	260	257	40.5%	0	0	0	0	0.0%	655	634	260	257	40.5%	43
44	MID-SOUTH INS CO	13,614	14,229	8,973	7,438	52.3%	387	393	1,054	1,108	281.8%	16,877	17,412	13,599	14,417	82.8%	44
45	MONUMENTAL LIFE INS CO	1,580	UN	UN	UN	UN	698	UN	UN	UN	UN	5,093	UN	UN	UN	UN	45

Small Group Activity Report Summary
1995 Premiums and Claims for All Health Benefit Plans
(In 000's)

Exhibit J

ROW #	COMPANY NAME	3 - 25 MARKET PREM WRITTEN	3 - 25 MARKET PREM EARNED	3 - 25 MARKET CLAIMS PAID	3 - 25 MARKET CLAIMS INC	3 - 25 MARKET INC LOSS RATIO	ONE-MAN / SELF-EMPLOYED GROUPS PREM WRITTEN	ONE-MAN / SELF-EMPLOYED GROUPS PREM EARNED	ONE-MAN / SELF-EMPLOYED GROUPS CLAIMS PAID	ONE-MAN / SELF-EMPLOYED GROUPS CLAIMS INC	ONE-MAN / SELF-EMPLOYED GROUPS INC LOSS RATIO	1 - 49 MARKET PREM WRITTEN	1 - 49 MARKET PREM EARNED	1 - 49 MARKET CLAIMS PAID	1 - 49 MARKET CLAIMS INC	1 - 49 MARKET INC LOSS RATIO	ROW #
46	NATIONAL AMERICAN LIFE INS CO OF PA	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	46
47	NATIONAL FOUNDATION LIFE INS CO	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	47
48	NATIONAL GROUP LIFE INS CO	1,764	983	382	746	75.9%	156	87	34	66	75.8%	2,961	1,722	715	1,305	75.8%	48
49	NATIONAL HEALTH LIFE INS CO	48	47	25	25	51.9%	451	450	233	233	51.9%	573	572	297	297	51.9%	49
50	NATIONWIDE LIFE INS CO	5,038	5,038	422	3,867	76.8%	214	214	321	392	183.5%	9,245	9,245	7,213	6,848	71.9%	50
51	NEW ENGLAND MUTUAL LIFE INS CO	279	276	59	62	22.3%	16	16	5	11	70.7%	306	303	77	84	27.7%	51
52	NEW YORK LIFE INS CO	4,554	4,593	3,454	3,409	74.2%	673	679	538	531	78.2%	7,088	7,148	5,663	5,590	78.2%	52
53	OPTIMUM CHOICE OF THE CAROLINAS, INC	0	0	0	0	0.0%	0	0	0	0	0.0%	0	0	0	0	0.0%	53
54	PACIFIC MUTUAL LIFE INS CO	1,379	2,115	1,493	1,487	70.3%	162	159	114	112	70.6%	2,608	2,561	1,740	1,731	67.6%	54
55	PAN AMERICAN LIFE INS CO	1,535	1,534	1,063	1,139	74.3%	39	39	68	75	190.6%	1,727	1,728	1,272	1,368	79.1%	55
56	PARTNERS NATIONAL HEALTH PLAN OF NC	2,785	2,785	200	2,216	79.6%	71	71	31	35	48.8%	5,037	4,037	3,440	3,806	94.3%	56
57	PFL LIFE INS CO	175	174	71	108	61.8%	16,028	15,961	6,553	9,879	61.9%	16,580	18,512	6,779	10,220	61.9%	57
58	PHOENIX AMERICAN LIFE INS CO	85	85	52	53	62.5%	0	0	0	0	0.0%	405	405	340	364	89.7%	58
59	PHOENIX HOME LIFE MUTUAL INS CO	328	328	183	174	52.9%	0	0	0	0	0.0%	612	812	425	423	69.1%	59
60	PHP, INC	8,302	8,438	5,830	6,050	71.7%	228	232	160	166	71.4%	11,495	11,684	8,029	8,331	71.3%	60
61	PIONEER LIFE INS CO OF ILLINOIS	665	370	147	281	75.8%	50	28	11	21	75.8%	1,032	575	223	438	75.8%	61
62	PRINCIPAL HEALTH CARE OF THE CAROLINAS	UN	UN	UN	UN	UN	UN	UN	UN	UN	UN	UN	UN	UN	UN	#DIV/0!	62
63	PRINCIPAL MUTUAL LIFE INS CO	65,696	65,570	56,344	55,747	85.0%	998	996	1,089	1,077	108.2%	88,588	88,417	76,560	75,749	85.7%	63
64	PROTECTIVE LIFE INS CO	1,504	1,520	1,346	1,245	81.9%	641	648	617	570	88.0%	2,617	2,647	2,187	2,004	75.7%	64
65	PROVIDENT HEALTH PLAN INC OF NC	0	0	0	0	0.0%	0	0	0	0	0.0%	0	0	0	0	0.0%	65
66	PROVIDENT LIFE & ACCIDENT INS CO	771	1,606	1,024	1,120	69.8%	141	167	100	128	76.8%	1,371	2,958	1,733	1,894	64.0%	66
67	PRUDENTIAL HEALTH CARE PLAN INC	368	362	UN	278	76.8%	58	57	UN	44	76.9%	1,294	12,962	UN	977	7.5%	67
68	PRUDENTIAL INS CO OF AMERICA	10,204	11,420	6,726	8,301	72.7%	687	1,003	438	706	70.4%	12,307	14,873	8,351	10,722	73.1%	68
69	SAVERS LIFE INS CO	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	69
70	SECURITY LIFE INS CO OF AMERICA	22	105	47	55	52.7%	33	95	70	64	67.6%	55	218	145	151	69.5%	70
71	SENTRY LIFE INS CO	442	442	192	186	42.0%	39	39	115	122	314.6%	668	668	438	444	66.5%	71
72	TIME INS CO	2,914	2,948	2,459	2,614	88.7%	190	192	259	275	143.0%	3,838	3,882	3,305	3,514	90.5%	72
73	TMG LIFE INS CO	8,383	8,383	4,938	5,127	61.2%	317	317	137	166	53.0%	12,596	12,596	8,381	8,348	66.3%	73
74	TRAVELERS INS CO	25,385	22,614	19,358	20,167	89.2%	0	0	0	0	0.0%	36,457	32,335	28,199	29,180	90.2%	74
75	TRUSTMARK INSURANCE CO	8,454	8,454	7,428	8,826	104.4%	491	491	226	415	84.5%	16,300	16,300	12,404	14,630	89.8%	75
76	UNITED OF OMAHA INS CO	3,345	3,389	2,892	2,826	83.4%	115	117	0	0	UN	4,163	4,216	3,233	3,159	74.9%	76
77	UNITED STATES LIFE INS CO	232	229	184	169	73.6%	0	0	0	0	0.0%	269	267	266	250	93.9%	77
78	UNITED WISCONSIN LIFE INS CO	2,004	2,004	1,173	1,384	69.1%	1,922	1,922	1,221	1,221	63.5%	5,082	5,082	2,819	3,422	67.3%	78
79	UNITED WORLD LIFE INS CO	192	222	109	111	49.8%	31	33	0	0	UN	281	293	109	111	37.7%	79
80	US HEALTHCARE OF THE CAROLINAS, INC	0	0	0	0	0.0%	0	0	0	0	0.0%	0	0	0	0	0.0%	80
81	WELLPATH COMMUNITY HEALTH PLANS, INC	0	0	0	0	0.0%	0	0	0	0	0.0%	0	0	0	0	0.0%	81
82	WESTERN FIDELITY INS CO	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	82
	TOTAL	$460,974	$434,115	$332,048	$346,855	79.9%	$30,659	$30,287	$19,078	$22,961	75.8%	$641,799	$652,925	$505,969	$521,410	79.9%	

COLUMN AND ROW TOTALS MAY NOT ADD CORRECTLY DUE TO SOME CARRIERS' INABILITY TO PROVIDE THE DATA IN THE DETAIL REQUIRED

UN = UNKNOWN
N/A = NOT APPLICABLE
NR = NOT REPORTED

COMPANY NAME IN BOLD INDICATES A RISK ASSUMING CARRIER

NATIONWIDE LIFE INS CO INCLUDES EMPLOYERS LIFE INS CO OF WAUSAU
FIRST ALLMERICA FINANCIAL LIFE INS CO WAS FORMERLY STATE MUTUAL LIFE ASSUR CO OF AMERICA

1995 Market Share Based Upon All Benefit Plans
3-25 Market
(in 000's)

	COMPANY NAME	PREM WRITTEN	MARKET SHARE
1	BLUE CROSS BLUE SHIELD/NC	141,016	30.28%
2	PRINCIPAL MUTUAL LIFE INS CO	65,696	14.10%
3	JOHN ALDEN LIFE INS CO	46,640	10.01%
4	FEDERATED MUTUAL INS CO	33,303	7.15%
5	TRAVELERS INS CO	25,385	5.45%
6	MID-SOUTH INS CO	13,614	2.92%
7	GUARDIAN LIFE INS CO	13,537	2.91%
8	KAISER FOUNDATION HEALTH PLAN/NC	13,293	2.85%
9	EMPLOYERS HEALTH INS CO	10,513	2.26%
10	PRUDENTIAL INS CO OF AMERICA	10,204	2.19%
11	FORTIS BENEFITS INS CO	9,141	1.96%
12	TRUSTMARK INSURANCE CO	8,454	1.82%
13	TMG LIFE INS CO	8,383	1.80%
14	PHP, INC	8,302	1.78%
15	NATIONWIDE LIFE INS CO	5,038	1.08%
16	CENTRAL RESERVE LIFE INS CO	4,701	1.01%
17	NEW YORK LIFE INS CO	4,554	0.98%
18	UNITED OF OMAHA INS CO	3,345	0.72%
19	LINCOLN NATIONAL LIFE INS CO	3,230	0.69%
20	JEFFERSON-PILOT LIFE INS CO	3,186	0.68%
21	TIME INS CO	2,914	0.63%
22	PARTNERS NATIONAL HEALTH PLAN OF NC	2,785	0.60%
23	HOME LIFE FINANCIAL ASSURANCE CORP	2,738	0.59%
24	AETNA LIFE INS CO	2,494	0.54%
25	JOHN HANCOCK MUTUAL LIFE INS CO	2,192	0.47%
26	UNITED WISCONSIN LIFE INS CO	2,004	0.43%
27	NATIONAL GROUP LIFE INS CO	1,764	0.38%
28	MONUMENTAL LIFE INS CO	1,580	0.34%
29	PAN AMERICAN LIFE INS CO	1,535	0.33%
30	PROTECTIVE LIFE INS CO	1,504	0.32%
31	KANAWHA INS CO	1,447	0.31%
32	PACIFIC MUTUAL LIFE INS CO	1,379	0.30%
33	CENTENNIAL LIFE INS CO	1,318	0.28%
34	CUNA MUTUAL INSURANCE SOCIETY	1,198	0.26%
35	COLONIAL LIFE INS CO OF AMERICA	1,074	0.23%
36	PROVIDENT LIFE & ACCIDENT INS CO	771	0.17%
37	PIONEER LIFE INS CO OF ILLINOIS	665	0.14%
38	METROPOLITAN LIFE INS CO	655	0.14%
39	BOSTON MUTUAL LIFE INS CO	479	0.10%
40	GENERAL AMERICAN LIFE INS CO	471	0.10%
41	SENTRY LIFE INS CO	442	0.09%
42	PRUDENTIAL HEALTH CARE PLAN INC	368	0.08%
43	PHOENIX HOME LIFE MUTUAL INS CO	328	0.07%
44	NEW ENGLAND MUTUAL LIFE INS CO	279	0.06%
45	FRANKLIN LIFE INS CO	262	0.06%
46	GREAT-WEST LIFE & ANNUITY INS CO	248	0.05%
47	UNITED STATES LIFE INS CO	232	0.05%
48	CONNECTICUT GENERAL LIFE INS CO	219	0.05%
49	UNITED WORLD LIFE INS CO	192	0.04%
50	PFL LIFE INS CO	175	0.04%
51	AMERICAN NATIONAL LIFE INS CO	118	0.03%
52	LAMAR LIFE INS CO	90	0.02%
53	PHOENIX AMERICAN LIFE INS CO	85	0.02%
54	FIRST ALLMERICA FINANCIAL LIFE INS CO	66	0.01%
55	NATIONAL HEALTH LIFE INS CO	48	0.01%
56	LIFE INVESTORS INSURANCE CO OF AMER	47	0.01%
57	BANKERS UNTIED LIFE ASSUR CO	25	0.01%
58	SECURITY LIFE INS CO OF AMERICA	22	0.00%
59	ALLIANZ LIFE INS CO OF NORTH AMERICA	10	0.00%
60	DOCTORS HEALTH PLAN, INC	7	0.00%
61	AETNA HEALTH PLANS OF THE CAROLINAS, INC	0	0.00%
62	METRAHEALTH INS CO	0	0.00%
63	OPTIMUM CHOICE OF THE CAROLINAS, INC	0	0.00%
64	PROVIDENT HEALTH PLAN INC OF NC	0	0.00%
65	US HEALTHCARE OF THE CAROLINAS, INC	0	0.00%
66	WELLPATH COMMUNITY HEALTH PLANS, INC	0	0.00%
67	AMERICAN SERVICE LIFE INS CO	N/A	0.00%
68	DURHAM LIFE INS CO	N/A	0.00%
69	INDEPENDENT LIFE AND ACCIDENT INS CO	N/A	0.00%
70	MANUFACTURERS LIFE INS CO	N/A	0.00%
71	MAXICARE NORTH CAROLINA, INC	N/A	0.00%
72	NATIONAL AMERICAN LIFE INS CO OF PA	N/A	0.00%
73	NATIONAL FOUNDATION LIFE INS CO	N/A	0.00%
74	SAVERS LIFE INS CO	N/A	0.00%
75	WESTERN FIDELITY INS CO	N/A	0.00%
76	AMERICAN FIDELITY ASSUR CO	NR	0.00%
77	CELTIC LIFE INSURANCE COMPANY	NR	0.00%
78	CIGNA HEALTHCARE OF NORTH CAROLINA	UN	0.00%
79	EMPLOYERS LIFE INS CO OF WAUSAU	UN	0.00%
80	HEALTHSOURCE, NORTH CAROLINA	UN	0.00%
81	MAMSI LIFE AND HEALTH INS CO	UN	0.00%
82	PRINCIPAL HEALTH CARE OF THE CAROLINAS	UN	0.00%
	TOTAL	$465,765	100.00%

UN = UNKNOWN
N/A = NOT APPLICABLE
NR = NOT REPORTED

COMPANY NAME IN BOLD INDICATES A RISK ASSUMING CARRIER

NATIONWIDE LIFE INS CO INCLUDES EMPLOYERS LIFE INS CO OF WAUSAU
FIRST ALLMERICA FINANCIAL LIFE INS CO WAS FORMERLY STATE MUTUAL LIFE ASSUR CO OF AMERICA
CENTRAL RESERVE LIFE INS CO AND LAMAR LIFE INS CO REPORTED EARNED PREMIUM ONLY

1995 Market Share Based Upon All Benefit Plans
One-Man/Self-Employed Groups
(in 000's)

	COMPANY NAME	PREM WRITTEN	MARKET SHARE
1	PFL LIFE INS CO	16,026	52.27%
2	BLUE CROSS BLUE SHIELD/NC	4,023	13.12%
3	UNITED WISCONSIN LIFE INS CO	1,922	6.27%
4	PRINCIPAL MUTUAL LIFE INS CO	998	3.25%
5	JOHN HANCOCK MUTUAL LIFE INS CO	728	2.37%
6	MONUMENTAL LIFE INS CO	698	2.28%
7	PRUOENTIAL INS CO OF AMERICA	687	2.24%
8	NEW YORK LIFE INS CO	673	2.20%
9	PROTECTIVE LIFE INS CO	641	2.09%
10	TRUSTMARK INSURANCE CO	491	1.60%
11	NATIONAL HEALTH LIFE INS CO	451	1.47%
12	MIO-SOUTH INS CO	387	1.26%
13	GUARDIAN LIFE INS CO	338	1.10%
14	TMG LIFE INS CO	317	1.04%
15	FORTIS 8ENEFITS INS CO	306	1.00%
16	PHP, INC	228	0.74%
17	NATIONWIOE LIFE INS CO	214	0.70%
18	TIME INS CO	190	0.62%
19	PACIFIC MUTUAL LIFE INS CO	162	0.53%
20	HOME LIFE FINANCIAL ASSURANCE CORP	160	0.52%
21	NATIONAL GROUP LIFE INS CO	156	0.51%
22	PROVIDENT LIFE & ACCIDENT INS CO	141	0.46%
23	KAISER FOUNDATION HEALTH PLAN/NC	127	0.41%
24	UNITED OF OMAHA INS CO	115	0.38%
25	KANAWHA INS CO	72	0.24%
26	PARTNERS NATIONAL HEALTH PLAN OF NC	71	0.23%
27	PRUDENTIAL HEALTH CARE PLAN INC	58	0.19%
28	PIONEER LIFE INS CO OF ILLINOIS	50	0.16%
29	PAN AMERICAN LIFE INS CO	39	0.13%
30	SENTRY LIFE INS CO	39	0.13%
31	CENTENNIAL LIFE INS CO	35	0.12%
32	SECURITY LIFE INS CO OF AMERICA	33	0.11%
33	UNITED WORLD LIFE INS CO	31	0.10%
34	FRANKLIN LIFE INS CO	26	0.08%
35	NEW ENGLAND MUTUAL LIFE INS CO	16	0.05%
36	AMERICAN NATIONAL LIFE INS CO	5	0.02%
37	0OCTORS HEALTH PLAN, INC	4	0.01%
38	8OSTON MUTUAL LIFE INS CO	2	0.01%
39	JOHN ALOEN LIFE INS CO	0	0.00%
40	AETNA HEALTH PLANS OF THE CAROLINAS, INC	0	0.00%
41	AETNA LIFE INS CO	0	0.00%
42	ALLIANZ LIFE INS CO OF NORTH AMERICA	0	0.00%
43	BANKERS UNTIED LIFE ASSUR CO	0	0.00%
44	CENTRAL RESERVE LIFE INS CO	0	0.00%
45	COLONIAL LIFE INS CO OF AMERICA	0	0.00%
46	CONNECTICUT GENERAL LIFE INS CO	0	0.00%
47	CUNA MUTUAL INSURANCE SOCIETY	0	0.00%
48	EMPLOYERS HEALTH INS CO	0	0.00%
49	FEDERATED MUTUAL INS CO	0	0.00%
50	FIRST ALLMERICA FINANCIAL LIFE INS CO	0	0.00%
51	GENERAL AMERICAN LIFE INS CO	0	0.00%
52	GREAT-WEST LIFE & ANNUITY INS CO	0	0.00%
53	JEFFERSON-PILOT LIFE INS CO	0	0.00%
54	LAMAR LIFE INS CO	0	0.00%
55	LIFE INVESTORS INSURANCE CO OF AMER	0	0.00%
56	LINCOLN NATIONAL LIFE INS CO	0	0.00%
57	METRAHEALTH INS CO	0	0.00%
58	METROPOLITAN LIFE INS CO	0	0.00%
59	OPTIMUM CHOICE OF THE CAROLINAS, INC	0	0.00%
60	PHOENIX AMERICAN LIFE INS CO	0	0.00%
61	PHOENIX HOME LIFE MUTUAL INS CO	0	0.00%
62	PROVIOENT HEALTH PLAN INC OF NC	0	0.00%
63	TRAVELERS INS CO	0	0.00%
64	UNITEO STATES LIFE INS CO	0	0.00%
65	US HEALTHCARE OF THE CAROLINAS, INC	0	0.00%
66	WELLPATH COMMUNITY HEALTH PLANS, INC	0	0.00%
67	AMERICAN SERVICE LIFE INS CO	N/A	N/A
68	DURHAM LIFE INS CO	N/A	N/A
69	INOEPENOENT LIFE ANO ACCIOENT INS CO	N/A	N/A
70	MANUFACTURERS LIFE INS CO	N/A	N/A
71	MAXICARE NORTH CAROLINA, INC	N/A	N/A
72	NATIONAL AMERICAN LIFE INS CO OF PA	N/A	N/A
73	NATIONAL FOUNDATION LIFE INS CO	N/A	N/A
74	SAVERS LIFE INS CO	N/A	N/A
75	WESTERN FIDELITY INS CO	N/A	N/A
76	AMERICAN FIDELITY ASSUR CO	NR	NR
77	CELTIC LIFE INSURANCE COMPANY	NR	NR
78	CIGNA HEALTHCARE OF NORTH CAROLINA	UN	UN
79	EMPLOYERS LIFE INS CO OF WAUSAU	UN	UN
80	HEALTHSOURCE, NORTH CAROLINA	UN	UN
81	MAMSI LIFE ANO HEALTH INS CO	UN	UN
82	PRINCIPAL HEALTH CARE OF THE CAROLINAS	UN	UN
	TOTAL	$30,660	100.00%

UN = UNKNOWN
N/A = NOT APPLICABLE
NR = NOT REPORTED

COMPANY NAME IN BOLD INDICATES A RISK ASSUMING CARRIER

NATIONWIDE LIFE INS CO INCLUDES EMPLOYERS LIFE INS CO OF WAUSAU
FIRST ALLMERICA FINANCIAL LIFE INS CO WAS FORMERLY STATE MUTUAL LIFE ASSUR CO OF AMERICA
CENTRAL RESERVE LIFE INS CO AND LAMAR LIFE INS CO REPORTED EARNED PREMIUM ONLY

1999 Market Share Based Open Fill Benefit Plans

1-49 Market
(in 000's)

	COMPANY NAME	PREM WRITTEN	MARKET SHARE
1	BLUE CROSS BLUE SHIELD/NC	200,572	30.95%
2	PRINCIPAL MUTUAL LIFE INS CO	88,588	13.67%
3	JOHN ALDEN LIFE INS CO	60,274	9.30%
4	TRAVELERS INS CO	36,457	5.63%
5	GUARDIAN LIFE INS CO	22,021	3.40%
6	KAISER FOUNDATION HEALTH PLAN/NC	17,439	2.69%
7	MID-SOUTH INS CO	16,877	2.60%
8	PFL LIFE INS CO	16,580	2.56%
9	TRUSTMARK INSURANCE CO	16,300	2.52%
10	EMPLOYERS HEALTH INS CO	14,963	2.31%
11	FORTIS BENEFITS INS CO	13,015	2.01%
12	TMG LIFE INS CO	12,596	1.94%
13	PRUDENTIAL INS CO OF AMERICA	12,307	1.90%
14	PHP, INC	11,495	1.77%
15	JEFFERSON-PILOT LIFE INS CO	10,483	1.62%
16	NATIONWIDE LIFE INS CO	9,245	1.43%
17	NEW YORK LIFE INS CO	7,088	1.09%
18	AETNA LIFE INS CO	6,532	1.01%
19	CENTRAL RESERVE LIFE INS CO	6,138	0.95%
20	MONUMENTAL LIFE INS CO	5,093	0.79%
21	UNITED WISCONSIN LIFE INS CO	5,082	0.78%
22	PARTNERS NATIONAL HEALTH PLAN OF NC	5,037	0.78%
23	LINCOLN NATIONAL LIFE INS CO	4,718	0.73%
24	FEDERATED MUTUAL INS CO	4,224	0.65%
25	UNITED OF OMAHA INS CO	4,163	0.64%
26	TIME INS CO	3,838	0.59%
27	HOME LIFE FINANCIAL ASSURANCE CORP	3,821	0.59%
28	JOHN HANCOCK MUTUAL LIFE INS CO	3,735	0.58%
29	NATIONAL GROUP LIFE INS CO	2,961	0.46%
30	PROTECTIVE LIFE INS CO	2,617	0.40%
31	PACIFIC MUTUAL LIFE INS CO	2,608	0.40%
32	KANAWHA INS CO	2,227	0.34%
33	PAN AMERICAN LIFE INS CO	1,727	0.27%
34	CENTENNIAL LIFE INS CO	1,629	0.25%
35	CUNA MUTUAL INSURANCE SOCIETY	1,593	0.25%
36	COLONIAL LIFE INS CO OF AMERICA	1,460	0.23%
37	GREAT-WEST LIFE & ANNUITY INS CO	1,423	0.22%
38	PROVIDENT LIFE & ACCIDENT INS CO	1,371	0.21%
39	PRUDENTIAL HEALTH CARE PLAN INC	1,294	0.20%
40	PIONEER LIFE INS CO OF ILLINOIS	1,032	0.16%
41	FIRST ALLMERICA FINANCIAL LIFE INS CO	717	0.11%
42	AMERICAN NATIONAL LIFE INS CO	680	0.10%
43	GENERAL AMERICAN LIFE INS CO	672	0.10%
44	SENTRY LIFE INS CO	668	0.10%
45	METROPOLITAN LIFE INS CO	655	0.10%
46	PHOENIX HOME LIFE MUTUAL INS CO	612	0.09%
47	NATIONAL HEALTH LIFE INS CO	573	0.09%
48	BOSTON MUTUAL LIFE INS CO	557	0.09%
49	PHOENIX AMERICAN LIFE INS CO	405	0.06%
50	LIFE INVESTORS INSURANCE CO OF AMER	372	0.06%
51	NEW ENGLAND MUTUAL LIFE INS CO	306	0.05%
52	UNITED WORLD LIFE INS CO	281	0.04%
53	UNITED STATES LIFE INS CO	269	0.04%
54	CONNECTICUT GENERAL LIFE INS CO	219	0.03%
55	FRANKLIN LIFE INS CO	201	0.03%
56	LAMAR LIFE INS CO	90	0.01%
57	SECURITY LIFE INS CO OF AMERICA	55	0.01%
58	DOCTORS HEALTH PLAN, INC	35	0.01%
59	BANKERS UNTIED LIFE ASSUR CO	25	0.00%
60	ALLIANZ LIFE INS CO OF NORTH AMERICA	12	0.00%
61	AETNA HEALTH PLANS OF THE CAROLINAS, INC	0	0.00%
62	METRAHEALTH INS CO	0	0.00%
63	OPTIMUM CHOICE OF THE CAROLINAS, INC	0	0.00%
64	PROVIDENT HEALTH PLAN INC OF NC	0	0.00%
65	US HEALTHCARE OF THE CAROLINAS, INC	0	0.00%
66	WELLPATH COMMUNITY HEALTH PLANS, INC	0	0.00%
67	AMERICAN SERVICE LIFE INS CO	N/A	N/A
68	DURHAM LIFE INS CO	N/A	N/A
69	INDEPENDENT LIFE AND ACCIDENT INS CO	N/A	N/A
70	MANUFACTURERS LIFE INS CO	N/A	N/A
71	MAXICARE NORTH CAROLINA, INC	N/A	N/A
72	NATIONAL AMERICAN LIFE INS CO OF PA	N/A	N/A
73	NATIONAL FOUNDATION LIFE INS CO	N/A	N/A
74	SAVERS LIFE INS CO	N/A	N/A
75	WESTERN FIDELITY INS CO	N/A	N/A
76	AMERICAN FIDELITY ASSUR CO	NR	NR
77	CELTIC LIFE INSURANCE COMPANY	NR	NR
78	CIGNA HEALTHCARE OF NORTH CAROLINA	UN	UN
79	EMPLOYERS LIFE INS CO OF WAUSAU	UN	UN
80	HEALTHSOURCE, NORTH CAROLINA	UN	UN
81	MAMSI LIFE AND HEALTH INS CO	UN	UN
82	PRINCIPAL HEALTH CARE OF THE CAROLINAS	UN	UN
	TOTAL	$648,026	100.00%

UN = UNKNOWN
N/A = NOT APPLICABLE
NR = NOT REPORTED

COMPANY NAME IN BOLD INDICATES A RISK ASSUMING CARRIER

NATIONWIDE LIFE INS CO INCLUDES EMPLOYERS LIFE INS CO OF WAUSAU
FIRST ALLMERICA FINANCIAL LIFE INS CO WAS FORMERLY STATE MUTUAL LIFE ASSUR CO OF AMERICA
CENTRAL RESERVE LIFE INS CO AND LAMAR LIFE INS CO REPORTED EARNED INCOME ONLY

Appendix E

State Health Plan Purchasing Alliance

Report to the N.C. Health Care Reform Commission

STATE HEALTH PLAN
PURCHASING ALLIANCE BOARD
501 N. BLOUNT STREET
RALEIGH, NC 27604

Table of Contents

State Health Plan Purchasing Alliance Board

Summary of enabling legislation and start-up activities

The purpose and intent of the Alliance program is to increase the affordability, efficiency and fairness of health care coverage for small employers. In 1993, the General Assembly created the State Health Plan Purchasing Alliance Board (State Board) to promote the development of voluntary purchasing alliances. The mission of Alliances is to provide more affordable health care coverage for self-employed individuals and employees of participating small businesses in a manner similar to large employer groups. Alliances will allow members to benefit from the contracting expertise and the administrative savings that can result from pooled purchasing.

Alliances will make available a choice of insurance carriers, called Accountable Health Carriers, that would be responsible for arranging quality health services in a cost-effective manner. The State Board was required to develop rules for fair competition among these Accountable Health Carriers, including the offering of comparable benefits plans from each Accountable Health Carrier and the development of a risk assessment and adjustor to ensure that risk is being spread evenly across all participating carriers. The State Board is also responsible for analyzing data on clinical outcomes, customer satisfaction and other measures of performance from Accountable Health Carriers and regional Alliances.

The eleven-member State Board was appointed during the late fall of 1993. An executive director began work in January 1994, and two additional staff positions were added by May. A fourth person was added to the staff in February 1995.

Following several months of educational forums and concensus building, business groups led primarily by Chambers of Commerce expressed interest in becoming community sponsors for regional Alliances. The first such group, the Asheville Chamber of Commerce, supported by over 20 chambers in Western North Carolina, submitted a proposal in June 1994, which was accepted by the State Board in August.

The Pitt/Greenville Chamber of Commerce, in partnership with other chambers throughout Eastern North Carolina, submitted a proposal in November 1994, which the Board approved in December.

Following these proposals, the Board approved proposals from the Fayetteville Chamber of Commerce for 11 counties in Southeastern North Carolina and from Union County Chamber of Commerce for 9 counties in South-Central North Carolina in February 1995. The Board recently approved applications from the Durham Business and Professional Chain for the Triangle area and from the Wilkes Chamber of Commerce, in conjunction with the chambers in Watauga, Alleghany, Ashe and Caldwell counties, for counties in Northwest North Carolina and the Triad area.

In all, six regions are now incorporated and in operation as private, non-profit organizations. These corporations will serve as the governing structure and marketing units for the Alliance program.

In May 1995, the State Board negotiated a contract with HealthPlan Services, Inc., a third-party administrator on behalf of the Alliances to provide "back-office" support for each regional Alliance, including billing, marketing and other functions related to the support of the program.

Beginning in the early summer of 1995, the regional Alliances, the State Board and its staff and various interest groups have been participating in a series of work sessions to determine administrative procedures and rules, guidelines for sales, marketing and general alliance operation. A request for bids from Accountable Health Carriers was issued in August of this year, with bids returning in mid-October.

The Alliances, now operating under the name "Caroliance," have opened their doors for testing. Beginning mid-1996, an aggressive marketing campaign will begin.

As of March 31, over 3500 calls from small businesses have resulted in over 1800 quotes. Covered lives have doubled each month of operation and total 272. Just over 20 percent are small business people who previously had no insurance.

12/27/95
c:\docs\summary

CAROLIANCE REGIONAL EXECUTIVE DIRECTORS

NORTHWEST/TRIAD
Sandra Gambill
Wilkesboro
910-838-8662

TRIANGLE
Larry Hester
Raleigh
919-683-1047

EASTERN
Rex Hammond
Greenville
919-752-8237

WESTERN
Mike Moser
Asheville
704-687-7302

METROLINA
Dave Miles
Charlotte
704-283-6088

SOUTHEASTERN
Frank Dieter
Fayetteville
800-765-8456

CAROLIANCE
Health Plan Choices for Small Business

Duties of the
State Health Plan Purchasing Alliance Board*

(1) **MARKET AREAS.** Establish and modify market areas for alliances in the State.

Status: Complete.

Comments: Six market areas have been established within the State.

(2) **ACCOUNTABLE HEALTH CARRIERS.** Accept, determine eligibility, and designate carriers as Accountable Health Carriers.

Status: Ongoing.

Comments: At this point we have 14 carriers designated as Accountable Health Carriers.

(3) **COMMUNITY SPONSORS.** Establish Alliances with community sponsors for each market area determined by the Board.

Status: Complete.

Comments: Alliances incorporated in all six market areas

(4) **ANNUAL REVIEWS.** Conduct annual reviews of the performance of each Alliance a summary of which is to be provided to the General Assembly and each Alliance.

(a) Each Alliance shall submit data to the Board quarterly to assist the Board in its review. This data includes, but is not limited to, the following:
- (i) employer enrollment by employer size;
- (ii) industry sector;
- (iii) previous insurance status and number of employees within each insurance status;
- (iv) number of total eligible employers in the market area participating in the Alliance;

(v) number of insured lives by county and insured category, including employees, dependents and other insured categories;
(vi) profiles of potential employer membership by county;
(vii) premium ranges for each qualified health care plan for Alliance members categories;
(viii) type and resolution of member grievances;
(ix) surcharges; and
(x) Alliance financial statements.

Status: Ongoing.

Comments: The Third Party Administrator will help collect and report this information for alliances

(5) **ENROLLMENT PROCEDURES.** Develop standard enrollment procedures to be used in enrolling small employers and their eligible employees.

Status: Complete.

Comments: Developed cooperatively with carriers, agents and alliances.

(6) **CONDITIONS OF PARTICIPATION.** Establish conditions of participation for small employers and self-employed individuals that shall include, but not be limited to, the following:

(a) Assurances that the member small employer is a valid small employer group;
(b) Requirements involving qualified health plans;
(c) Minimum employer contribution requirements;
(d) Mechanism to provide for participation by eligible employees if their employer chooses not to participate; and
(e) Mechanisms, such a prepayment of premiums, to assure that payment will be made for coverage.

Status: Complete.

Comments: Rules developed cooperatively with carriers, agents and third party administrator.

(7) **RIGHT TO PURCHASE HEALTH CARE COVERAGE.** Ensure that any small employer or any employee of a small employer who qualifies may purchase health care coverage.

Status: Complete.

Comments: This has been accomplished through the guarantee issue provision and AHC participation requirements found in the request for proposals.

(8) **COMPLIANCE.** Ensure compliance with this Article by Alliances, small employers and employee enrollees.

Status: On-going

Comments: Quarterly reviews and reports

(9) **FINANCIAL CONDITION OF CARRIER.** Have the authority to request information about the financial condition of the carrier consistent with what is required to be submitted by the carrier to the Department of Insurance.

Status: Complete.

Comments: This has been accomplished by a including a provision in the Accountable Health Carrier designation process.

(10) **FAIR AND AFFIRMATIVE MARKETING.** Assure fair and affirmative marketing of the qualified health care plans.

Status: Complete.

Comments: The Board has adopted a fair and affirmative marketing policy. It is anticipated that this policy will be monitored through the annual review of each Alliance.

(11) **ADOPT RULES.** Adopt rules necessary to administer the provisions of this article.

Status: Complete.

Comments: Rules 100 - 400 series have gone before the Rules Review Committee and are included in Title 24, Chapter 5 of the North Carolina Administrative Code. 100 Series (Community Sponsors); 200 Series (Market Areas); 300 Series (Designation Process for Accountable Health Carriers); 400 Series (Participating Small Employers).

(12) **APPOINT ADVISORY COMMITTEES.** Appoint advisory committees that shall include persons with expertise in health benefits management and representatives of Accountable Health Carriers.

Status: A Designation Technical Review Committee and an AHC Advisory Committee have been appointed.

Comments: Future advisory committees will possibly include a Marketing Advisory Committee.

(13) **DEVELOP UNIFORM STANDARDS.** Develop uniform standards for the data that Alliances collect from Accountable Health Carriers.

Status: On-going

Comments: Currently using HEDIS data set. Further standards being developed in cooperation with carriers.

(14) **AUTHORITY TO SUE OR BE SUED.** Have the authority to sue or be sued, including taking action necessary for securing legal remedies on behalf of, or against Alliances, member small employers, or employee enrollees and their dependents.

Status: Complete.

Comments: None.

(15) **RECEIVE OR ACCEPT GRANTS.** Have the authority to receive or accept grants, funds or contributions.

Status: Ongoing.

Comments: None.

(16) **STANDARDIZED FORMS.** Develop and implement standardized forms for use by Accountable Health Carriers.

Status: Complete.

Comments: Third-party administrator will manage and update these forms with input from all carriers and agents.

(17) **SURCHARGES.** Review, and limit if necessary, surcharges charged by each Alliance for administrative costs.

Status: Ongoing.

Comments: Alliances will provide quarterly financial statements which will include fee schedules.

(18) **DEVELOP GUIDELINES FOR MARKETING.** Develop guidelines for marketing materials to be used in providing member small employers and their eligible employees with information regarding Accountable Health Carriers and their qualified health care plans.

Status: Complete.

Comments: Marketing policy adopted. State will work with third-party administrator and regional alliances to review all marketing materials.

(19) **GRIEVANCE PROCEDURES.** Develop grievance procedures to be used in resolving disputes between member small employers and Alliances.

Status: Ongoing.

Comments: Carriers have grievance procedures in place. Alliances are developing grievance procedures.

(20) **UNRESOLVED GRIEVANCES.** Receive, review, and act on appeals of grievances not resolved.

Status: Ongoing.

Comments: None to date

(21) **ANALYZE INFORMATION.** Analyze information collected from Accountable Health Carriers and other sources and report findings that assist in improving the delivery or purchase of cost-effective health care.

Status: Pending.

Comments: None

(22) **ANNUAL REPORT.** Report annually on the operation of the Board to the Joint Legislative Commission on Governmental Operations and the Governor.

Status: The SHPPA Board staff will appear before the Legislative Commission on Governmental Operations on February 6 and/or 7, 1996.

*This list of Board Duties is a synopsis of the rules set out in the *Small Employer Health Insurance Purchasing Alliance Act* under *North Carolina General Statutes Section 143-626. Duties of the Board.*

			1993						1994				1995				1996			
AJOR ACTIVITIES	Jul	Aug	Sep	Oct	Nov	Dec	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Legislation Passed - HB 729	X																	
State Board appointed		X	X	X														
Staffing of Board																		
Executive Director							X											
Deputy Director								X										
Policy Analyst											X							
Clerical								X										
Other/Contract Employees									X									
Alliance Formation																		
Community Sponsor Solicitation							X	X	X	X	X	X	X					
Formulate Administrative Rules							X											
Issue Community Sponsor RFP								X										
Designate Community Sponsors																		
Western NC									X									
NW/Triad													X					
Metrolina									X									
NorthCentral (Triangle)													X					
Southeastern											X							
Eastern										X								
Third Party Administrator																		
Issue RFP										X								
Award Bid											X							
Contract Negotiation											X	X						
Operational in North Carolina													X					
Accountable Health Carriers																		
Designation Process Begun											X							
RFP Development												X	X					

E-13

			1993					1994				1995			1996			
MAJOR ACTIVITIES (con't)	Jul	Aug	Sep	Oct	Nov	Dec	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Accountable Health Carriers (con't)																		
Issue Initial RFP													X					
]														X	X	X	X	X
Pre-Alliance Operations																		
Develop Marketing Strategies												X	X	X	X			
Implement Marketing														X	X	X	X	X
Agent Training & Orientation														X	X	X	X	X
Alliance Operations																		
Offer Products														X	X	X	X	X
Develop risk adjustment mechanism															X	X		
Develop satisfaction survey															X	X		
Finalize grievance procedures															X			

MEMORANDUM

TO: Dr. Jim Jones, Executive Director
Health Care Reform Commission

FROM: Robert F. Joyce, Executive Director
State Health Plan Purchasing Alliance Board

DATE: March 31, 1996

SUBJECT: Hurdles to Implementation: A Report on Purchasing Alliance Start-up

I would like to take this opportunity to review for you and the members of the commission three major issues that have slowed start-up of the health insurance purchasing co-operatives in North Carolina:

Community Sponsor Development. The process of finding appropriate local partners for starting these alliances has been the most time-consuming aspect of the program. Since the legislation required that each alliance have a community sponsor, it was necessary for the Board's staff to recruit, solicit, and educate various business entities on the process of starting and running health purchasing alliances.

The strongest support for the alliances came from the rural and smaller urban areas of the state where a vast majority of a Chamber of Commerce's membership is small businesses. The more difficult areas for generating sponsors were the Triad and Raleigh/Durham. In the Triangle, the Durham Business and Professional Chain took the lead where neither the Greater Raleigh Chamber nor the Durham Chamber had offered. For the counties from Alamance to the northwest, five smaller chambers led by the Wilkes County Chamber of Commerce have just recently formed the last alliance.

There is now complete coverage of all 100 counties for health purchasing cooperatives. This process has included individual incorporation proceedings. Since each alliance is a non-profit corporation, whose boards of directors must be a majority of small business owners and employees, this process has also required the recruitment and approval of initial boards by the State Board. There are specific ethics and conflict-of-interest requirements which the Attorney General's office has been very helpful in completing.

Beginning after the second year of operation, each regional alliance's Board of Directors will be elected by the membership of that alliance. This aspect of the alliance's governance is unique in that the role of the State Board in the oversight of each alliance is greatly reduced, ensuring long-term autonomy for each alliance and greater ownership by small business. Although there was considerable time spent educating small business, we believe this investment will pay big dividends because the business communities have ownership and understand that this program's success is their responsibility, not state governments.

Agent Appointment. Due to the current state of North Carolina insurance law, determining the appropriate and legal means of appointing agents within the alliance program has been difficult. North Carolina General Statutes require that an agent be appointed prior to solicitation of business. However, the general business practice in the state is for an agent to become appointed "at sale" or after that agent has sold a policy to a business.

To ensure that all agents could easily sell plans offered in the alliances, a procedure was developed in cooperation with the Department of Insurance that allowed the alliance to distribute quotes on alliance products to any agent who called and requested one. Once a group policy had been the sold, the administrator would notify the carrier of the new business and the agent of record, after which the carrier would have 30 days to notify the alliance of the agent's appointment.

Immediately before start-up, this policy was criticized by some agent groups as being contrary to state law. Accordingly, the policy was dropped and the alliances currently require that all agents be appointed with all carriers who offer products before a quote can be sent to that agent. However, this new policy is being criticized by participating agents as being cumbersome and unlike current business practice in the insurance market.

We are looking at two possible solutions to this problem: (1) replacement of NC's appointment prior to solicitation requirement with appointment at sale or (2) development of a single alliance appointment to replace the numerous appointments now necessary. Replacing the pre-solicitation requirement in favor of appointment at sale would bring the statutes into alignment with current (but possibly illegal) business practice. A number of states have already adopted appointment at sale.

Developing a single alliance appointment would be an acceptable solution to this problem as well. however, the State Board and the alliances are concerned about issues with liability, coordination of this appointment procedure and interference with the traditional relationships between carrier and agent.

We feel that this issue must be re-addresses soon to correct any confusion with agent participation in the program.

Recruitment and Education of Accountable Health Carriers. Another aspect of North Carolina's efforts to develop health insurance purchasing alliances for small businesses is the cooperative role between the carrier community, the regional alliances and the State Board. During the first nine months of 1995, this partnership worked together to write a Request for Proposal which outlined the numerous administrative issues that needed to be resolved before the alliance program could begin.

Every carrier has entirely unique business practices for their day-to-day operations. The most important opportunity for saving for the carriers is the administrative savings to be offered through the alliance for certain services. To maximize these savings and to fit into each carrier's systems, we found it to be very important that potential problem areas be identified, discussed

and solved in cooperative with Accountable Health Carriers. Some of these problem areas included:

- providing pre-existing credit for small business owners who currently have individual coverage;
- whether to impose an 18-month waiting period or and 18-month pre-existing condition limitations on late enrollees;
- how enrollment information will be transmitted from the administrator to each carrier;
- the design of a single enrollment form containing necessary information and questions from the employers and their employees; and
- the methodology and standards for group underwriting.

We found that by addressing these issues in an open forum among the State Board staff, the directors of the regional alliances, the Accountable Health Carriers, and agents, most decisions were found easily on common ground. But the shear size of the number and type of issues to be addresses were staggering, causing delays in the production of the final RFP.

As this memo outlines, the State Health Plan Purchasing Alliance Board has undertaken a number of significant issues in getting alliances started. The staff has attempted to closely follow the spirit of the legislation which was very business-oriented and non-bureaucratic in its approach.

At this point we do feel that we have the infrastructure in place to allow these purchasing coops to grow and prosper. The reaction of the marketplace will be the key to long term success.

c:\mjimjone

MEMORANDUM

To: Dr. Jim Jones, Executive Director, Health Care Reform Commission

From: Robert F. Joyce, Executive Director

Re: Role of Third-Party Administrator

Date: March 31, 1996

In February 1995, HealthPlan Services Inc., was hired to provide back-office support to each of the six alliances.

This contractor will provide enrollment and eligibility processing, billing and collection of premiums, payment of commissions to agents, remittance of premiums to carriers, reporting of data to alliances and State Board and statewide marketing of the alliance program.

Originally, each alliance was authorized to hire its own administration. Carriers made us aware that this was not efficient and we then considered contracting with our administrator which has proven to be more cost effective.

The alliances are very pleased with the customer service provided by the Third-Party Administrator.

RFJ:bjl

c:\mJones

CAROLIANCE

2547 Ravenhill Drive
Suite 103
Fayetteville, NC 28303

FOR IMMEDIATE RELEASE

Wednesday, March 13, 1996

Contact: Frank Dieter, Executive Director
CAROLIANCE ~ Southeastern Region
(800) 765-8456

Fayetteville: Caroliance~Southeastern Region (formerly known as Southeastern NC Health Alliance) announces a 9% reduction in insurance premiums for its Employer's Life of Wausau health benefit plans. Reduced premiums are available for new plans with effective dates of April 1, 1996

"We are pleased to see the premium reduction," states Mr. Frank Dieter, Executive Director, Caroliance~Southeastern Region. "It is a step forward in assisting our small business customer in obtaining affordable quality health insurance for their employees." Employer's Life of Wausau is one of four insurance companies committed to working with the health plan purchasing alliance program in the Southeastern Region of North Carolina. Employer's Life offers the greatest variety of plan choices among the participating companies.

Caroliance~Southeastern Region is one of six purchasing coops created to increase the affordability, efficiency, and fairness of health coverage for small employers. Originally established through the efforts of regional chambers of commerce lead by the Fayetteville Chamber of Commerce and HealthCare 99, Caroliance came into existence in May 1995 as a private, non-profit corporation governed by an eleven member board of directors composed of small business owners. Health plans became available for sale in November 1995 and are sold through local professional insurance agents.

"Small employers, those with 49 or fewer employers, have a difficult time obtaining affordable health coverage in today's healthcare climate." Dieter says. "Caroliance works for the small employer by pooling their purchasing power and requiring insurance companies to set premiums according to adjusted community rating procedures. This helps to stabilize the cost of insurance products." Several plan options exist and some plans are available on a guaranteed issue basis, meaning that employer groups cannot be turned down.

Caroliance~Southeastern Region covers Bladen, Cumberland, Harnett, Hoke, Lee, Montgomery, Moore, Richmond, Robeson, Sampson, and Scotland counties. "We advocate for 12,900 small employers with over 90,000 employees in this region and want to have a positive effect on the rate of uninsured individuals." Dieter continues. "Statewide, the uninsured rate is 14% of the population. In our region, the rate is 15% - 17% depending on the county. The majority of the uninsured are employed by small business and it is this group that Caroliance intends to help."

"The 9% premium reduction by Employer's Life in our second quarter of operation is very encouraging." Dieter summarized. "We expect to see competitive prices and more carriers participating in future months."

For more information about Caroliance, its products and prices, interested employers may call 1-800-765-8456 or write to 2547 Ravenhill Drive, Suite 103, Fayetteville, NC 28303.

Appendix F

Uninsured

Projected Personal Health Spending
North Carolina and U.S., 1995-2030

Type of Service	Per Capita Spending, by Calendar Year						Annual Change	
	1995	2000	2005	2010	2020	2030	1995-2000	1995-2030
North Carolina Most Likely								
PERSONAL HEALTH	$ 2,851	$ 4,113	$ 5,882	$ 8,549	$ 16,962	$ 34,094	7.6%	7.3%
Hospital care	$ 1,192	$ 1,648	$ 2,269	$ 3,167	$ 5,825	$ 10,632	6.7%	6.5%
Physicians' services	$ 583	$ 887	$ 1,341	$ 2,055	$ 4,271	$ 8,515	8.8%	8.0%
Dentists' services	$ 126	$ 169	$ 219	$ 288	$ 478	$ 808	6.0%	5.5%
Other professional services	$ 183	$ 293	$ 457	$ 723	$ 1,694	$ 3,936	9.8%	9.2%
Drugs/medical sundries	$ 311	$ 436	$ 617	$ 884	$ 1,795	$ 3,642	7.0%	7.3%
Eyeglasses/appliances	$ 40	$ 50	$ 61	$ 76	$ 111	$ 162	4.6%	4.1%
Nursing home care	$ 257	$ 377	$ 541	$ 787	$ 1,602	$ 3,741	8.0%	8.0%
Home health	$ 89	$ 142	$ 204	$ 297	$ 598	$ 1,390	9.9%	8.2%
Other health services	$ 71	$ 111	$ 172	$ 272	$ 588	$ 1,266	9.4%	8.6%
OTHER HEALTH SPENDING	$ 349	$ 455	$ 599	$ 803	$ 1,425	$ 2,520	5.5%	5.8%
Administration	$ 165	$ 229	$ 321	$ 456	$ 894	$ 1,688	6.8%	6.9%
Public Health	$ 89	$ 115	$ 145	$ 186	$ 296	$ 480	5.3%	4.9%
Research	$ 50	$ 61	$ 73	$ 89	$ 128	$ 184	3.7%	3.8%
Construction	$ 45	$ 51	$ 60	$ 71	$ 106	$ 167	2.5%	3.8%
TOTAL HEALTH SPENDING	$ 3,200	$ 4,568	$ 6,481	$ 9,352	$ 18,387	$ 36,613	7.4%	7.2%
Percent Distribution								
PERSONAL HEALTH	89.1%	90.0%	90.8%	91.4%	92.3%	93.1%		
Hospital Care	37.2%	36.1%	35.0%	33.9%	31.7%	29.0%		
Physicians' Services	18.2%	19.4%	20.7%	22.0%	23.2%	23.3%		
Dentists' Services	3.9%	3.7%	3.4%	3.1%	2.6%	2.2%		
Other Professional Services	5.7%	6.4%	7.1%	7.7%	9.2%	10.8%		
Drugs/Medical Sundries	9.7%	9.5%	9.5%	9.5%	9.8%	9.9%		
Eyeglasses/Appliances	1.2%	1.1%	0.9%	0.8%	0.6%	0.4%		
Nursing Home Care	8.0%	8.3%	8.4%	8.4%	8.7%	10.2%		
Home Health	NA	NA	3.2%	3.2%	3.3%	3.8%		
Other Health Services	2.2%	2.4%	2.7%	2.9%	3.2%	3.5%		
OTHER HEALTH SPENDING	10.9%	10.0%	9.2%	8.6%	7.7%	6.9%		
Administration	5.1%	5.0%	5.0%	4.9%	4.9%	4.6%		
Public Health	2.8%	2.5%	2.2%	2.0%	1.6%	1.3%		
Research	1.6%	1.3%	1.1%	1.0%	0.7%	0.5%		
Construction	1.4%	1.1%	0.9%	0.8%	0.6%	0.5%		
TOTAL HEALTH SPENDING	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%		

Source: Chris Conover, Duke University Center for Health Policy Research Education (684-8026)

Projected Personal Health Spending Under Alternative Scenarios
North Carolina and U.S., 1995-2030

Type of Service	Per Capita Spending, by Calendar Year 1995	2000	2005	2010	2020	2030	Annual Change 1995-2000	1995-2030
North Carolina Draconian Scenario								
PERSONAL HEALTH	$ 2,851	$ 3,945	$ 5,503	$ 7,798	$ 14,193	$ 26,658	6.7%	6.6%
Hospital care	$ 1,192	$ 1,583	$ 2,121	$ 2,880	$ 4,824	$ 8,377	5.9%	5.7%
Physicians' services	$ 583	$ 833	$ 1,222	$ 1,815	$ 3,439	$ 6,364	7.4%	7.1%
Nursing home care	$ 257	$ 369	$ 521	$ 745	$ 1,393	$ 2,957	7.5%	7.2%
All other personal health	$ 820	$ 1,159	$ 1,639	$ 2,358	$ 4,537	$ 8,959	7.2%	7.1%
OTHER HEALTH SPENDING	$ 349	$ 447	$ 579	$ 763	$ 1,276	$ 2,173	5.1%	5.4%
TOTAL HEALTH SPENDING	$ 3,200	$ 4,392	$ 6,081	$ 8,561	$ 15,468	$ 28,830	6.5%	6.5%
North Carolina High-Side Scenario								
PERSONAL HEALTH	$ 2,851	$ 4,163	$ 6,102	$ 9,092	$ 20,305	$ 47,154	7.9%	8.3%
Hospital care	$ 1,192	$ 1,669	$ 2,346	$ 3,343	$ 6,846	$ 14,430	7.0%	7.4%
Physicians' services	$ 583	$ 894	$ 1,382	$ 2,165	$ 4,951	$ 11,025	8.9%	8.8%
Nursing home care	$ 257	$ 381	$ 561	$ 837	$ 1,883	$ 4,969	8.2%	8.8%
All other personal health	$ 820	$ 1,219	$ 1,813	$ 2,747	$ 6,626	$ 16,730	8.3%	9.0%
OTHER HEALTH SPENDING	$ 349	$ 457	$ 609	$ 827	$ 1,586	$ 3,060	5.5%	6.4%
TOTAL HEALTH SPENDING	$ 3,200	$ 4,620	$ 6,711	$ 9,919	$ 21,891	$ 50,214	7.6%	8.2%
SPENDING BURDEN								
Per Capita Income	$ 20,146	$ 24,186	$ 29,743	$ 38,093	$ 61,471	98,150.2	3.7%	4.6%
Personal Health % of Income								
Most Likely	14.2%	17.0%	19.8%	22.4%	27.6%	34.7%	3.7%	2.6%
Draconian Scenario	14.2%	16.3%	18.5%	20.5%	23.1%	27.2%	2.9%	1.9%
High-Side Scenario	14.2%	17.2%	20.5%	23.9%	33.0%	48.0%	4.0%	3.6%
Total Health % of Income								
Most Likely	15.9%	18.9%	21.8%	24.6%	29.9%	37.3%	3.5%	2.5%
Draconian Scenario	15.9%	18.2%	20.4%	22.5%	25.2%	29.4%	2.7%	1.8%
High-Side Scenario	15.9%	19.1%	22.6%	26.0%	35.6%	51.2%	3.8%	3.4%
Relative Spending Index (US = 100)								
Personal Health	86.8	87.9	88.1	88.4	89.0	89.9	0.2%	0.1%
Total Health	86.8	87.9	88.2	88.4	89.1	90.0	0.2%	0.1%
Per Capita Income	90.3	90.9	91.2	91.4	91.8	92.3	0.1%	0.1%
Personal Health % of Income	96.1	96.6	96.7	96.7	97.0	97.4	0.1%	0.0%
Total Health % of Income	96.1	96.6	96.7	96.8	97.0	97.5	0.1%	0.0%

Source: Derived from projections of national spending obtained from Health Care Financing Administration

Source: Chris Conover, Duke University Center for Health Policy Research Education (684-8026)

Number with Inadequate Coverage
North Carolina, 1995

Family Income as Percent of Poverty	Total Population	Total "At Risk"	Uninsured		Underinsured	
			All Year	Part Year	Private	Public
Below 100%	990,663	542,038	202,120	146,996	113,583	79,339
100-125%	312,673	193,624	50,097	34,654	68,838	40,035
126-200%	1,130,696	508,681	131,802	115,580	159,743	101,557
201-400%	2,441,749	766,400	171,797	205,732	314,815	74,056
Over 400%	2,029,924	330,880	71,286	107,947	134,840	16,808
TOTAL	6,905,705	2,341,624	627,101	610,909	791,819	311,795
			Percent			
Below 100%	100%	55%	20%	15%	11%	8%
100-125%	100%	62%	16%	11%	22%	13%
126-200%	100%	45%	12%	10%	14%	9%
201-400%	100%	31%	7%	8%	13%	3%
Over 400%	100%	16%	4%	5%	7%	1%
TOTAL	100%	34%	9%	9%	11%	5%
			Percent			
Below 100%	14%	23%	32%	24%	14%	25%
100-125%	5%	8%	8%	6%	9%	13%
126-200%	16%	22%	21%	19%	20%	33%
201-400%	35%	33%	27%	34%	40%	24%
Over 400%	29%	14%	11%	18%	17%	5%
TOTAL	100%	100%	100%	100%	100%	100%
	[A]		[B]		[C]	[D]

Notes:

[A] All figures reported in March 1995 Current Population Survey (excludes institutionalized individuals, such as prisons, patients in state mental facilities and nursing home residents).

[B] The uninsured include all individuals who have neither private coverage (individual or employer-based, including government employees) nor public coverage (Medicare, Medicaid, military).

[C] *Underinsured* is defined as having a 1 percent chance of spending more than 10 percent of family income on health care in any particular year, given a family's income and level of private health coverage.

[D] Underinsured public includes all individuals below 400 percent of poverty and 50% above this income level if they rely exclusively on Medicare coverage and have no other form of supplemental coverage such as a private supplemental policy or Medicaid.

SUMMARY RANKINGS OF INADEQUATE COVERAGE
NORTH CAROLINA COUNTIES, 1995

	TOTAL POPULATION						Annual "At Risk" Poor per 1,000 Residents			Daily Uninsured Poor per 1,000 Residents		
	Annual "At Risk"			Average Daily Uninsured								
	Percent	Index (NC=100)	Rank	Percent	Index (NC=100)	Rank	Number	Index (NC=100)	Rank	Number	Index (NC=100)	Rank
Alamance	30.0	91.9	17	10.1	78.9	3	49.8	65.8	6	25.0	63.9	4
Alexander	29.0	88.6	3	10.3	80.4	6	57.2	75.6	19	30.6	78.3	19
Alleghany	40.2	123.1	94	15.2	118.4	58	160.9	212.7	95	69.0	176.6	87
Anson	32.4	99.1	26	13.7	106.9	29	82.3	108.8	44	44.5	113.9	45
Ashe	35.7	109.1	58	14.6	113.7	47	125.8	166.3	85	66.6	170.3	81
Avery	37.5	114.8	78	16.7	130.5	79	94.6	125.1	55	54.1	138.4	63
Beaufort	36.3	111.0	65	15.1	118.1	56	115.2	152.3	72	54.9	140.6	65
Bertie	36.5	111.6	67	15.3	119.3	63	145.0	191.7	93	67.0	171.4	82
Bladen	34.5	105.7	43	16.0	125.2	72	117.1	154.8	75	70.4	180.0	89
Brunswick	37.2	113.8	71	16.9	132.2	82	94.7	125.2	56	56.6	144.8	70
Buncombe	29.6	90.7	11	10.2	79.4	4	62.5	82.6	26	34.0	87.1	27
Burke	28.7	87.7	2	9.6	75.1	1	55.6	73.5	15	28.7	73.4	14
Cabarrus	29.8	91.2	13	10.5	81.7	12	42.3	56.0	3	23.4	60.0	2
Caldwell	34.5	105.5	41	14.2	110.8	34	61.9	81.8	25	31.9	81.7	25
Camden	44.9	137.5	100	22.5	175.5	100	115.5	152.6	73	64.9	166.1	80
Carteret	39.3	120.2	88	18.2	141.8	92	75.0	99.1	35	46.7	119.4	50
Caswell	38.0	116.2	82	17.2	134.6	87	96.3	127.3	58	47.5	121.6	52
Catawba	29.1	89.1	4	9.9	77.4	2	34.1	45.1	1	19.3	49.4	1
Chatham	35.7	109.2	59	14.9	116.2	55	60.0	79.4	22	28.3	72.5	12
Cherokee	34.2	104.8	37	14.6	113.6	46	123.4	163.1	82	71.6	183.1	90
Chowan	36.0	110.3	62	15.9	124.3	69	92.3	122.0	53	55.5	141.9	68
Clay	38.3	117.2	85	16.6	129.9	78	123.1	162.8	80	67.2	172.1	83
Cleveland	33.9	103.9	32	14.2	111.1	37	54.8	72.5	12	30.5	78.0	16
Columbus	33.8	103.4	29	15.2	118.5	59	129.5	171.2	87	74.5	190.7	92
Craven	39.9	122.2	90	18.2	142.2	93	77.6	102.6	39	39.6	101.3	38
Cumberland	32.5	99.6	27	13.1	102.3	26	90.8	120.0	52	46.5	118.9	49
Currituck	40.5	123.9	95	19.9	155.5	97	56.2	74.3	16	35.5	90.8	32
Dare	40.6	124.3	96	19.0	148.4	95	61.0	80.6	24	37.4	95.7	36
Davidson	29.5	90.4	9	10.4	81.5	11	57.9	76.5	20	31.7	81.1	24
Davie	30.3	92.7	19	10.6	82.4	14	50.4	66.6	8	25.1	64.4	5
Duplin	34.3	104.9	38	14.8	115.3	54	107.6	142.3	70	58.5	149.6	73
Durham	30.9	94.5	22	10.3	80.7	8	70.2	92.8	33	28.6	73.1	13
Edgecombe	34.2	104.6	34	14.7	114.9	51	100.9	133.3	63	55.4	141.7	67
Forsyth	30.0	91.8	15	10.4	81.0	10	56.7	74.9	17	28.3	72.4	11
Franklin	30.1	92.1	18	12.0	93.5	23	77.0	101.8	38	45.5	116.5	47
Gaston	29.5	90.2	8	10.3	80.6	7	54.0	71.4	11	31.6	80.8	23
Gates	42.3	129.5	99	20.6	160.9	99	93.1	123.1	54	50.7	129.6	56
Graham	36.6	112.0	69	16.2	126.7	74	180.7	238.9	97	109.6	280.3	100
Granville	37.6	115.0	79	15.7	122.6	67	82.4	109.0	45	34.2	87.5	29
Greene	35.6	109.1	57	16.0	124.7	70	103.4	136.8	65	52.3	133.8	62
Guilford	30.0	91.9	16	10.5	82.2	13	56.7	75.0	18	29.0	74.1	15
Halifax	35.5	108.7	54	16.0	124.8	71	134.8	178.2	91	74.7	191.2	93
Harnett	36.4	111.2	66	16.8	131.5	81	103.7	137.0	66	57.1	146.0	71
Haywood	36.5	111.7	68	15.7	122.3	66	76.7	101.4	37	46.1	117.9	48
Henderson	35.6	109.0	56	14.2	110.9	35	60.0	79.3	21	34.0	87.1	28
Hertford	35.2	107.7	48	16.2	126.5	73	130.0	171.8	88	77.5	198.2	94
Hoke	30.6	93.7	21	13.4	104.6	27	97.2	128.5	59	48.3	123.7	53
Hyde	40.0	122.3	91	20.0	156.1	98	139.9	184.9	92	89.0	227.7	96
Iredell	34.6	105.7	44	14.5	113.1	45	51.0	67.4	9	27.3	69.9	9
Jackson	38.0	116.2	83	16.6	129.6	77	115.9	153.2	74	60.9	155.8	75

NOTE: Annual "at risk" includes all persons who are uninsured or underinsured at least part of the year.

	TOTAL POPULATION						Annual "At Risk" Poor per 1,000 Residents			Daily Uninsured Poor per 1,000 Residents		
	Annual "At Risk"			Average Daily Uninsured								
	Percent	Index (NC=100)	Rank	Percent	Index (NC=100)	Rank	Number	Index (NC=100)	Rank	Number	Index (NC=100)	Rank
Johnston	34.8	106.4	46	15.6	121.5	65	80.7	106.7	42	43.0	110.1	41
Jones	37.5	114.7	77	17.0	132.8	86	124.0	163.9	81	69.9	178.9	88
Lee	35.5	108.7	55	14.6	114.3	49	89.4	118.1	50	43.8	112.2	44
Lenoir	34.4	105.3	40	13.7	107.3	31	97.9	129.4	61	41.8	106.9	43
Lincoln	29.4	89.9	6	10.8	84.0	17	51.6	68.1	10	30.8	78.8	21
Macon	35.5	108.7	53	14.1	110.2	33	96.8	128.0	57	52.9	135.2	59
Madison	37.2	113.8	72	14.2	111.1	36	133.5	176.4	90	60.7	155.2	74
Martin	30.3	92.8	20	11.8	91.8	22	103.9	137.3	67	50.2	128.4	58
McDowell	40.2	123.2	93	17.8	139.3	89	104.3	137.9	69	46.0	117.8	51
Mecklenburg	29.4	90.0	7	10.7	83.2	15	50.5	66.8	7	27.3	70.0	8
Mitchell	37.5	114.7	76	15.8	123.3	68	102.6	135.7	64	52.2	133.5	61
Montgomery	34.2	104.6	33	14.4	112.6	42	70.2	92.8	34	40.6	103.9	39
Moore	35.3	108.2	52	14.0	109.6	32	62.3	82.4	27	30.5	77.9	20
Nash	34.2	104.7	36	14.3	111.9	39	74.9	99.0	36	36.0	92.1	34
New Hanover	29.6	90.5	10	11.1	87.0	20	81.5	107.8	43	49.2	125.9	54
Northhampton	37.3	114.3	74	17.8	138.6	88	115.8	153.0	76	66.3	169.6	85
Onslow	38.7	118.5	86	17.0	132.3	83	89.5	118.4	49	43.4	110.9	42
Orange	35.2	107.8	50	12.7	99.2	25	127.4	168.3	83	54.5	139.4	60
Pamlico	40.2	122.9	92	17.9	139.4	90	127.7	168.8	86	64.6	165.4	79
Pasquotank	37.8	115.7	80	17.0	132.5	84	109.9	145.3	71	54.1	138.4	66
Pender	36.1	110.4	63	16.5	128.4	76	98.5	130.2	60	54.7	140.0	64
Perquimans	39.6	121.2	89	18.1	141.2	91	122.8	162.3	84	65.5	167.7	84
Person	34.2	104.7	35	14.5	113.1	44	63.5	84.0	28	34.1	87.3	30
Pitt	33.5	102.6	28	11.6	90.7	21	162.2	214.4	96	72.9	186.5	91
Polk	37.9	116.0	81	15.4	119.9	64	60.6	80.1	23	30.0	76.7	17
Randolph	29.7	90.8	12	10.3	80.8	9	48.9	64.6	5	26.9	68.9	7
Richmond	34.5	105.6	42	14.6	114.1	48	88.1	116.5	51	48.8	124.7	55
Robeson	33.9	103.9	31	14.8	115.2	53	129.2	170.8	89	67.4	172.4	86
Rockingham	34.9	106.9	47	14.4	112.3	41	68.4	90.4	31	36.2	92.6	35
Rowan	29.2	89.5	5	10.2	79.7	5	48.3	63.8	4	27.1	69.4	10
Rutherford	34.4	105.1	39	13.7	107.2	30	68.2	90.1	32	34.5	88.2	31
Sampson	35.3	107.9	49	15.2	119.0	60	119.7	158.2	78	61.2	156.6	76
Scotland	32.4	99.0	25	14.4	112.1	40	84.4	111.6	47	50.8	130.0	57
Stanly	35.7	109.3	60	14.7	114.4	50	65.7	86.9	29	32.8	83.9	26
Stokes	31.0	95.0	23	12.1	94.8	24	53.8	71.1	13	28.2	72.1	16
Surry	34.7	106.2	45	13.7	106.8	28	66.9	88.5	30	31.1	79.6	22
Swain	37.2	114.0	73	15.3	119.1	62	199.5	263.8	99	106.0	271.1	99
Transylvania	35.9	109.9	61	14.7	114.9	52	79.8	105.5	41	45.2	115.6	46
Tyrrell	39.3	120.2	87	19.7	154.1	96	143.9	190.3	94	87.5	224.0	97
Union	28.4	87.0	1	10.7	83.6	16	39.4	52.1	2	23.3	59.7	3
Vance	33.8	103.5	30	14.4	112.6	43	98.6	130.4	62	55.3	141.4	69
Wake	30.0	91.7	14	10.9	85.2	18	56.1	74.2	14	27.4	70.1	6
Warren	41.0	125.5	97	17.0	132.7	85	196.2	259.4	98	85.1	217.8	95
Washington	38.2	117.0	84	18.5	144.4	94	105.3	139.3	68	62.0	158.6	78
Watauga	41.6	127.3	98	16.8	131.4	80	217.6	287.7	100	105.3	269.5	98
Wayne	37.4	114.4	75	16.4	128.4	75	85.7	113.3	48	40.9	104.7	40
Wilkes	35.3	108.1	51	14.2	111.2	38	84.3	111.5	46	38.4	98.4	37
Wilson	36.2	110.9	64	15.1	118.2	57	116.6	154.2	77	56.4	144.4	72
Yadkin	31.3	95.8	24	10.9	85.5	19	78.4	103.6	40	35.2	90.1	33
Yancey	36.8	112.6	70	15.2	119.0	61	122.2	161.6	79	61.7	157.8	77
STATE TOTAL	32.7	100.0		12.8	100.0		75.6	100.0		39.1	100.0	
Lowest County	28.4	87.0		9.6	75.1		34.2	45.2		19.3	49.5	
Highest County	44.9	137.5		22.5	175.5		217.6	287.7		111.0	284.0	

ANNUAL MEDICALLY INDIGENT "AT RISK"
NORTH CAROLINA COUNTIES, 1995

	TOTAL "AT RISK"					"AT RISK" BELOW POVERTY				
	Total	Uninsured		Underinsured		Total	Uninsured		Underinsured	
	"At Risk"	All Year	Part Year	Private	Public	"At Risk"	All Year	Part Year	Private	Public
	Percent of Total Population					Percent of Below Poverty Population				
Alamance	30.0	6.9	6.8	10.9	5.4	51.8	18.8	13.6	8.0	11.4
Alexander	29.0	7.0	6.9	11.1	4.0	54.0	20.9	15.2	7.0	11.0
Alleghany	40.2	10.5	9.6	12.6	7.5	76.1	23.5	17.1	21.3	14.1
Anson	32.4	9.4	9.1	8.5	5.4	43.7	17.1	12.4	3.6	10.7
Ashe	35.7	10.1	9.2	10.1	6.2	63.2	24.1	17.6	10.5	11.0
Avery	37.5	11.4	11.1	8.8	6.2	60.4	24.9	18.1	3.7	13.6
Beaufort	36.3	10.4	9.9	10.4	5.6	55.0	18.9	13.8	12.3	10.0
Bertie	36.5	10.6	9.8	10.1	6.1	52.6	17.6	12.8	12.9	9.4
Bladen	34.5	11.1	10.2	8.0	5.2	49.9	21.6	15.7	3.6	8.9
Brunswick	37.2	11.6	11.2	9.0	5.4	57.2	24.6	17.9	6.6	8.0
Buncombe	29.6	7.0	6.7	10.4	5.5	51.4	20.2	14.7	6.9	9.6
Burke	28.7	6.6	6.4	11.0	4.7	50.7	18.9	13.7	7.9	10.2
Cabarrus	29.8	7.1	7.1	10.5	5.1	48.6	19.4	14.1	3.7	11.4
Caldwell	34.5	9.6	9.7	10.8	4.4	53.7	20.0	14.6	9.3	9.8
Camden	44.9	15.3	15.0	9.6	4.9	66.9	27.1	19.7	12.6	7.3
Carteret	39.3	12.4	12.3	9.9	4.8	60.9	27.4	19.9	7.2	6.5
Caswell	38.0	11.8	11.6	10.1	4.5	54.7	19.5	14.2	10.4	10.7
Catawba	29.1	6.7	6.8	11.1	4.5	44.9	18.3	13.3	3.7	9.5
Chatham	35.7	10.1	10.2	11.0	4.4	56.6	19.3	14.0	13.0	10.3
Cherokee	34.2	10.1	9.1	8.3	6.8	57.0	23.9	17.4	6.1	9.7
Chowan	36.0	10.9	10.5	8.4	6.3	49.0	21.2	15.4	3.8	8.5
Clay	38.3	11.5	10.7	8.7	7.4	64.0	25.2	18.3	7.7	12.7
Cleveland	33.9	9.7	9.7	9.4	5.1	46.5	18.6	13.6	3.7	10.6
Columbus	33.8	10.5	9.5	8.0	5.7	50.4	20.9	15.2	3.7	10.6
Craven	39.9	12.4	12.4	10.5	4.6	53.7	19.8	14.4	12.0	7.5
Cumberland	32.5	9.0	8.6	12.5	2.5	59.5	22.0	16.0	17.3	4.3
Currituck	40.5	13.5	13.8	9.0	4.2	52.9	24.1	17.5	3.6	7.7
Dare	40.6	12.9	13.1	10.6	4.1	68.9	30.5	22.2	9.7	6.5
Davidson	29.5	7.1	6.9	11.5	3.9	54.8	21.7	15.8	8.9	8.4
Davie	30.3	7.2	7.2	11.4	4.6	54.6	19.7	14.3	7.1	13.6
Duplin	34.3	10.2	9.6	9.5	5.0	52.1	20.4	14.9	8.0	8.8
Durham	30.9	7.0	6.9	13.1	3.8	54.9	16.1	11.7	20.8	6.2
Edgecombe	34.2	10.1	9.6	8.4	6.1	44.9	17.8	12.9	3.9	10.3
Forsyth	30.0	7.1	7.0	11.4	4.6	49.9	18.0	13.1	11.1	7.8
Franklin	30.1	8.2	7.8	10.2	3.9	49.6	21.2	15.4	4.4	8.6
Gaston	29.5	7.1	6.9	11.0	4.6	47.5	20.0	14.6	3.8	9.1
Gates	42.3	14.0	14.0	9.0	5.4	55.4	21.8	15.8	8.4	9.4
Graham	36.6	11.4	9.6	9.2	6.4	67.5	29.6	21.5	8.1	8.4
Granville	37.6	10.7	10.7	11.4	4.8	57.6	17.2	12.5	16.9	10.9
Greene	35.6	10.9	10.6	10.3	3.9	51.7	18.9	13.7	12.3	6.8
Guilford	30.0	7.2	7.1	11.5	4.3	52.3	19.3	14.0	11.9	7.0
Halifax	35.5	11.1	10.1	8.4	5.9	49.4	19.8	14.4	7.2	8.1
Harnett	36.4	11.5	11.1	10.0	3.7	55.3	22.0	16.0	10.6	6.7
Haywood	36.5	10.7	10.5	9.0	6.4	55.8	24.2	17.6	3.7	10.3
Henderson	35.6	9.7	9.6	8.9	7.4	53.5	21.9	15.9	6.5	9.2
Hertford	35.2	11.2	10.2	7.9	5.9	49.1	21.1	15.4	4.4	8.2
Hoke	30.6	9.2	8.8	10.2	2.5	44.0	15.8	11.5	12.5	4.2
Hyde	40.0	13.8	12.7	7.5	5.9	55.5	25.5	18.5	3.8	7.7
Iredell	34.6	9.8	10.0	10.2	4.5	50.4	19.5	14.2	7.2	9.6
Jackson	38.0	11.4	10.8	10.9	4.8	64.8	24.6	17.9	14.4	7.9

Uninsured includes all individuals without Medicaid, Medicare, CHAMPUS, employer-provided group health insurance or individually purchased health insurance. *Privately underinsured* includes those with at least a 1 percent chance of spending more than 10% of family income on health care in a particular year, given that family's income and private health coverage. *Publicly underinsured* includes all persons below 400% of poverty who rely exclusively on Medicare coverage, along with half of those above

	TOTAL "AT RISK"					"AT RISK" BELOW POVERTY				
	Total	Uninsured		Underinsured		Total	Uninsured		Underinsured	
	"At Risk"	All Year	Part Year	Private	Public	"At Risk"	All Year	Part Year	Private	Public
	Percent of Total Population					Percent of Below Poverty Population				
Johnston	34.8	10.6	10.4	10.1	3.6	52.5	20.2	14.7	9.1	8.5
Jones	37.5	11.7	11.0	9.3	5.5	56.9	23.2	16.9	8.3	8.6
Lee	35.5	10.0	9.8	10.6	5.2	56.4	20.0	14.5	13.7	8.2
Lenoir	34.4	9.4	9.2	10.1	5.8	46.0	14.2	10.3	11.9	9.7
Lincoln	29.4	7.3	7.2	10.8	4.1	50.1	21.6	15.7	3.9	8.8
Macon	35.5	9.7	9.2	8.8	7.8	61.3	24.1	17.6	5.7	13.8
Madison	37.2	9.8	9.1	6.8	11.4	63.2	20.7	15.1	3.7	23.7
Martin	30.3	8.1	7.5	10.8	3.9	47.7	16.6	12.1	12.0	7.0
McDowell	40.2	12.1	12.0	12.3	3.8	63.8	20.3	14.8	22.8	5.9
Mecklenburg	29.4	7.3	7.2	11.7	3.3	49.0	19.1	13.9	10.4	5.6
Mitchell	37.5	10.8	10.4	9.5	6.7	59.0	21.7	15.8	7.3	14.3
Montgomery	34.2	9.8	9.7	9.7	5.0	46.1	19.3	14.0	3.8	9.0
Moore	35.3	9.5	9.6	9.4	6.9	52.7	18.6	13.5	10.9	9.7
Nash	34.2	9.8	9.7	11.3	3.5	51.2	17.8	12.9	13.4	7.2
New Hanover	29.6	7.7	7.1	10.3	4.5	54.3	23.6	17.2	7.8	5.6
Northhampton	37.3	12.2	11.6	7.3	6.3	46.3	19.1	13.9	3.8	9.5
Onslow	38.7	11.5	11.5	13.9	1.9	71.5	25.0	18.2	24.6	3.7
Orange	35.2	8.8	8.1	15.5	2.8	84.8	26.2	19.1	36.2	3.4
Pamlico	40.2	12.3	11.7	10.8	5.4	63.5	23.2	16.9	15.1	8.3
Pasquotank	37.8	11.6	11.2	10.1	4.9	52.2	18.5	13.5	13.2	7.0
Pender	36.1	11.3	10.9	9.3	4.6	53.3	21.4	15.5	8.8	7.6
Perquimans	39.6	12.4	11.8	8.9	6.5	53.6	20.6	15.0	9.5	8.4
Person	34.2	9.8	9.8	9.6	5.0	45.9	17.8	12.9	5.0	10.2
Pitt	33.5	8.1	7.0	14.6	3.8	68.7	22.3	16.2	24.1	6.1
Polk	37.9	10.4	10.6	9.1	7.8	58.1	20.8	15.1	8.2	14.1
Randolph	29.7	7.0	7.0	11.4	4.2	54.3	21.6	15.7	7.3	9.7
Richmond	34.5	10.0	9.6	9.5	5.4	48.8	19.5	14.2	5.6	9.5
Robeson	33.9	10.2	9.4	10.0	4.4	50.2	18.9	13.7	10.3	7.3
Rockingham	34.9	9.8	9.7	10.0	5.4	52.2	19.9	14.5	7.1	10.7
Rowan	29.2	7.0	6.9	10.9	4.5	47.5	19.3	14.0	5.4	8.8
Rutherford	34.4	9.3	9.3	10.2	5.5	51.7	18.9	13.7	7.6	11.5
Sampson	35.3	10.5	9.8	9.9	5.1	54.0	19.9	14.5	10.5	9.1
Scotland	32.4	9.8	9.4	9.0	4.2	42.2	18.3	13.3	3.7	6.8
Stanly	35.7	9.9	10.0	10.6	5.2	55.4	20.0	14.5	10.5	10.5
Stokes	31.0	8.2	8.3	11.1	3.4	51.2	19.4	14.1	6.6	11.2
Surry	34.7	9.3	9.3	10.3	5.9	54.2	18.2	13.2	9.3	13.5
Swain	37.2	10.8	8.9	11.4	6.1	68.8	26.4	19.2	14.7	8.6
Transylvania	35.9	10.1	9.8	9.3	6.8	56.1	22.9	16.7	7.9	8.7
Tyrrell	39.3	13.6	12.6	6.9	6.2	54.1	23.7	17.3	3.7	9.4
Union	28.4	7.3	7.3	10.8	3.0	43.8	18.7	13.6	3.6	7.9
Vance	33.8	9.9	9.4	9.3	5.2	47.4	19.2	13.9	6.2	8.1
Wake	30.0	7.4	7.4	12.3	2.8	62.3	21.9	15.9	18.7	5.7
Warren	41.0	11.8	10.6	12.8	5.8	65.2	20.4	14.8	21.6	8.3
Washington	38.2	12.7	12.2	7.9	5.5	48.1	20.4	14.9	3.8	9.0
Watauga	41.6	11.8	10.1	16.1	3.5	92.2	32.2	23.4	32.5	4.1
Wayne	37.4	11.2	11.1	10.8	4.3	53.2	18.3	13.3	12.8	8.7
Wilkes	35.3	9.7	9.6	11.1	4.9	58.5	19.3	14.0	13.2	12.1
Wilson	36.2	10.4	9.9	11.1	4.9	55.2	19.3	14.0	14.2	7.7
Yadkin	31.3	7.5	7.2	11.6	4.9	60.5	19.6	14.3	14.4	12.3
Yancey	36.8	10.5	9.8	10.0	6.5	61.4	22.4	16.3	10.6	12.2
STATE TOTAL	32.7	8.8	8.5	11.1	4.4	54.7	20.4	14.8	11.5	8.0
Lowest County	28.4	6.6	6.4	6.8	1.9	42.2	14.2	10.3	3.6	3.4
Highest County	44.9	15.3	15.0	16.1	11.4	92.2	32.2	23.4	36.2	23.7

AVERAGE DAILY HEALTH INSURANCE COVERAGE, BY SOURCE
NORTH CAROLINA COUNTIES, 1995

	TOTAL POPULATION					TOTAL BELOW POVERTY				
	Total	Private Only	Medi-care	Medi-caid	Unin-sured	Total	Private Only	Medi-care	Medi-caid	Unin-sured
	Percent Distribution									
Alamance	100.0	67.2	17.8	8.0	10.1	100.0	10.8	25.8	55.6	26.0
Alexander	100.0	70.8	12.9	8.3	10.3	100.0	9.7	25.2	52.5	28.9
Alleghany	100.0	54.8	23.9	10.3	15.2	100.0	27.7	32.0	32.7	32.6
Anson	100.0	54.1	17.4	17.8	13.7	100.0	5.0	24.2	63.5	23.6
Ashe	100.0	56.2	19.9	12.8	14.6	100.0	14.4	24.9	43.4	33.4
Avery	100.0	54.6	19.7	12.5	16.7	100.0	5.0	30.6	53.4	34.5
Beaufort	100.0	53.9	18.1	16.0	15.1	100.0	16.6	22.8	51.3	26.2
Bertie	100.0	46.4	19.4	22.4	15.3	100.0	17.4	21.5	54.6	24.3
Bladen	100.0	50.1	16.8	19.9	16.0	100.0	5.2	20.7	57.0	30.0
Brunswick	100.0	55.1	18.3	12.9	16.9	100.0	9.1	18.9	52.3	34.1
Buncombe	100.0	64.8	18.3	9.9	10.2	100.0	9.5	21.7	55.0	28.0
Burke	100.0	69.1	15.0	8.9	9.6	100.0	11.1	22.6	54.3	26.1
Cabarrus	100.0	67.9	16.7	7.8	10.5	100.0	5.0	25.8	60.3	26.9
Caldwell	100.0	64.9	14.3	9.2	14.2	100.0	12.6	22.1	53.4	27.7
Camden	100.0	53.7	15.9	10.6	22.5	100.0	17.2	16.5	41.4	37.6
Carteret	100.0	58.9	16.1	9.7	18.2	100.0	9.6	14.9	52.7	37.9
Caswell	100.0	58.3	14.0	13.0	17.2	100.0	14.7	23.4	49.5	27.0
Catawba	100.0	70.2	14.6	7.8	9.9	100.0	5.0	21.3	68.7	25.4
Chatham	100.0	65.9	14.3	7.5	14.9	100.0	17.7	23.1	47.4	26.7
Cherokee	100.0	52.2	22.6	14.7	14.6	100.0	12.9	22.8	45.5	33.1
Chowan	100.0	49.0	20.2	18.4	15.9	100.0	5.0	18.9	65.5	29.4
Clay	100.0	52.7	22.7	12.0	16.6	100.0	12.9	27.4	41.9	34.9
Cleveland	100.0	60.0	17.0	11.8	14.2	100.0	5.0	24.3	67.1	25.8
Columbus	100.0	47.4	18.1	22.5	15.2	100.0	5.0	24.2	58.8	29.0
Craven	100.0	56.9	15.3	12.3	18.2	100.0	15.7	17.3	57.1	27.4
Cumberland	100.0	69.5	8.3	10.6	13.1	100.0	23.6	9.9	46.6	30.5
Currituck	100.0	59.2	14.3	9.1	19.9	100.0	5.0	17.7	57.3	33.4
Dare	100.0	63.1	14.4	6.1	19.0	100.0	12.9	15.4	46.0	42.3
Davidson	100.0	71.0	12.6	8.2	10.4	100.0	12.1	18.7	52.1	30.0
Davie	100.0	68.5	17.0	6.9	10.6	100.0	9.5	35.1	50.4	27.3
Duplin	100.0	56.1	16.0	16.0	14.8	100.0	12.1	19.9	52.1	28.3
Durham	100.0	69.2	12.6	10.1	10.3	100.0	27.5	14.2	53.3	22.3
Edgecombe	100.0	49.1	17.9	21.5	14.7	100.0	5.1	21.3	64.2	24.7
Forsyth	100.0	68.1	14.5	9.5	10.4	100.0	14.9	16.9	56.4	24.9
Franklin	100.0	64.6	12.5	13.1	12.0	100.0	6.6	19.2	56.9	29.3
Gaston	100.0	66.8	15.0	10.5	10.3	100.0	5.0	20.6	62.1	27.8
Gates	100.0	51.8	17.3	13.3	20.6	100.0	11.3	21.2	53.4	30.1
Graham	100.0	49.5	21.2	16.8	16.2	100.0	11.1	19.6	42.1	41.0
Granville	100.0	61.1	15.1	10.7	15.7	100.0	22.7	24.2	50.2	23.9
Greene	100.0	58.8	12.4	15.0	16.0	100.0	17.6	15.5	50.4	26.1
Guilford	100.0	68.5	14.4	9.1	10.5	100.0	16.3	16.1	56.3	26.7
Halifax	100.0	44.8	19.2	23.4	16.0	100.0	9.7	18.5	57.5	27.4
Harnett	100.0	60.0	12.1	13.2	16.8	100.0	16.5	15.3	47.3	30.5
Haywood	100.0	55.3	21.3	11.5	15.7	100.0	5.0	23.7	56.0	33.5
Henderson	100.0	55.9	25.0	9.3	14.2	100.0	8.9	20.9	55.7	30.3
Hertford	100.0	44.7	18.3	23.9	16.2	100.0	5.9	18.2	60.8	29.3
Hoke	100.0	62.8	7.8	17.3	13.4	100.0	22.0	9.4	52.7	21.9
Hyde	100.0	43.0	18.3	21.9	20.0	100.0	5.0	16.6	58.4	35.3
Iredell	100.0	64.8	15.2	8.2	14.5	100.0	10.0	22.0	54.8	27.0
Jackson	100.0	58.8	16.0	11.4	16.6	100.0	19.8	18.3	42.6	34.0

	TOTAL POPULATION					TOTAL BELOW POVERTY				
	Total	Private Only	Medi-care	Medi-caid	Unin-sured	Total	Private Only	Medi-care	Medi-caid	Unin-sured
Johnston	100.0	61.1	13.9	11.9	15.6	100.0	12.8	23.4	52.0	27.6
Jones	100.0	51.6	18.0	16.6	17.0	100.0	11.2	19.6	51.1	31.8
Lee	100.0	59.5	17.0	11.8	14.6	100.0	18.9	18.5	50.2	27.5
Lenoir	100.0	52.8	18.8	18.0	13.7	100.0	16.1	22.1	56.9	20.1
Lincoln	100.0	69.1	13.9	8.7	10.8	100.0	5.4	20.7	56.6	30.4
Macon	100.0	54.5	25.1	10.6	14.1	100.0	10.3	31.1	45.1	32.9
Madison	100.0	62.6	10.0	14.9	14.2	100.0	18.4	14.8	47.5	28.5
Martin	100.0	53.1	21.6	17.3	11.8	100.0	16.9	27.6	53.5	23.5
McDowell	100.0	51.3	25.1	10.2	17.8	100.0	31.0	27.2	41.8	29.1
Mecklenburg	100.0	71.6	11.0	8.7	10.7	100.0	14.1	12.8	56.7	26.3
Mitchell	100.0	54.4	21.3	12.3	15.8	100.0	10.5	31.9	47.4	30.1
Montgomery	100.0	56.4	16.9	15.2	14.4	100.0	5.0	21.2	67.1	27.3
Moore	100.0	57.5	23.7	8.9	14.0	100.0	15.3	22.8	50.8	26.2
Nash	100.0	62.9	13.0	12.1	14.3	100.0	18.2	18.7	55.5	24.7
New Hanover	100.0	64.5	15.3	11.8	11.1	100.0	11.0	13.2	52.6	32.4
Northhampton	100.0	41.3	20.3	24.2	17.8	100.0	5.0	21.8	65.1	27.2
Onslow	100.0	69.6	6.5	8.1	17.0	100.0	31.6	8.9	43.3	34.1
Orange	100.0	74.6	9.5	4.9	12.7	100.0	49.6	8.0	21.8	34.7
Pamlico	100.0	54.3	18.0	13.0	17.9	100.0	20.2	19.3	43.6	32.3
Pasquotank	100.0	54.0	15.2	16.5	17.0	100.0	18.1	15.1	52.6	26.1
Pender	100.0	56.8	15.7	13.9	16.5	100.0	13.4	18.0	50.3	29.6
Perquimans	100.0	46.5	20.9	18.2	18.1	100.0	12.8	18.9	53.4	29.4
Person	100.0	60.7	15.7	11.9	14.5	100.0	8.8	22.5	57.6	25.2
Pitt	100.0	64.3	12.2	14.0	11.6	100.0	32.2	14.0	39.8	30.5
Polk	100.0	55.6	26.1	7.5	15.4	100.0	11.1	32.0	48.6	28.6
Randolph	100.0	70.5	14.0	7.6	10.3	100.0	9.8	22.2	56.6	30.0
Richmond	100.0	54.2	17.3	16.9	14.6	100.0	7.4	21.6	62.8	27.7
Robeson	100.0	52.5	14.0	21.2	14.8	100.0	14.1	16.7	55.4	26.5
Rockingham	100.0	60.0	17.6	11.1	14.4	100.0	9.6	24.2	57.1	27.8
Rowan	100.0	68.6	14.9	8.9	10.2	100.0	7.4	19.9	58.7	27.0
Rutherford	100.0	60.9	17.8	10.6	13.7	100.0	10.2	26.0	54.1	26.4
Sampson	100.0	55.3	16.1	16.2	15.2	100.0	15.4	20.6	49.0	27.9
Scotland	100.0	53.0	13.5	21.5	14.4	100.0	5.0	15.5	72.2	25.4
Stanly	100.0	61.5	17.3	9.6	14.7	100.0	14.1	24.0	54.6	28.4
Stokes	100.0	70.2	11.5	8.1	12.1	100.0	10.2	26.5	52.1	27.7
Surry	100.0	61.0	19.4	9.3	13.7	100.0	12.6	31.1	50.5	25.4
Swain	100.0	51.3	19.0	17.8	15.3	100.0	19.5	18.9	41.3	36.3
Transylvania	100.0	55.8	22.8	10.7	14.7	100.0	10.7	20.0	50.4	31.5
Tyrrell	100.0	43.4	18.3	21.8	19.7	100.0	5.0	19.9	54.9	34.2
Union	100.0	72.8	10.0	8.3	10.7	100.0	5.4	18.2	61.6	26.2
Vance	100.0	51.2	17.0	20.3	14.4	100.0	8.2	18.5	65.6	26.8
Wake	100.0	75.4	9.6	5.8	10.9	100.0	26.3	13.1	43.3	29.7
Warren	100.0	50.5	17.1	18.4	17.0	100.0	29.2	17.8	41.0	28.7
Washington	100.0	46.2	17.7	20.7	18.5	100.0	5.0	20.7	63.6	28.6
Watauga	100.0	67.5	11.5	6.1	16.8	100.0	44.6	9.3	17.4	42.2
Wayne	100.0	59.3	13.8	12.8	16.4	100.0	17.2	20.0	53.6	25.9
Wilkes	100.0	62.8	15.1	10.5	14.2	100.0	17.8	26.1	48.8	26.7
Wilson	100.0	55.3	16.2	16.2	15.1	100.0	18.9	18.0	51.6	27.3
Yadkin	100.0	67.3	16.7	8.0	10.9	100.0	20.2	29.1	41.4	27.5
Yancey	100.0	54.4	20.8	13.2	15.2	100.0	14.4	27.7	44.4	31.3
STATE TOTAL	100.0	64.5	14.4	10.8	12.8	100.0	15.8	18.3	52.5	28.3
Lowest County	100.0	41.3	6.5	4.9	9.6	100.0	5.0	8.0	17.4	20.1
Highest County	100.0	75.4	26.1	24.2	22.5	100.0	49.6	35.1	72.2	42.3

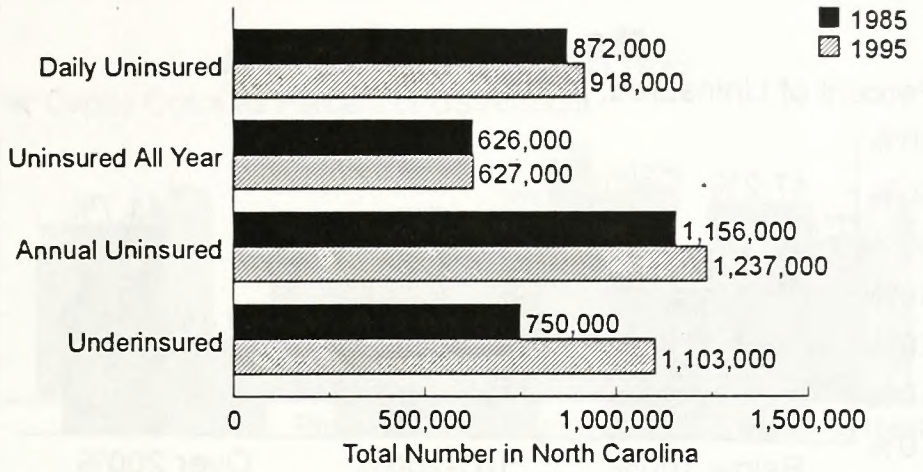
AVERAGE DAILY UNINSURED AND UNINSURED POOR, BY AGE
NORTH CAROLINA COUNTIES, 1995

	TOTAL UNINSURED					UNINSURED BELOW POVERTY				
	Total	Under 6	6 to 17	18 to 64	65 +	Total	Under 6	6 to 17	18 to 64	65 +
Alamance	11,575	789	1,499	9,124	163	2,879	391	390	2,039	59
Alexander	3,099	192	438	2,430	39	913	109	137	646	20
Alleghany	1,451	75	194	1,153	29	636	37	104	479	16
Anson	3,315	235	525	2,505	50	1,044	136	200	686	22
Ashe	3,354	166	418	2,712	58	1,538	136	183	1,190	29
Avery	2,545	143	333	2,030	39	820	78	107	616	18
Beaufort	6,629	436	986	5,116	90	2,383	303	381	1,660	39
Bertie	3,152	215	542	2,354	41	1,338	178	268	875	18
Bladen	4,752	306	729	3,652	64	2,048	233	343	1,442	30
Brunswick	10,193	625	1,339	8,098	131	3,449	462	459	2,486	42
Buncombe	19,214	1,245	2,609	15,078	282	6,428	798	917	4,608	105
Burke	7,784	520	1,065	6,098	101	2,325	314	334	1,634	43
Cabarrus	11,466	819	1,613	8,901	134	2,541	289	390	1,816	46
Caldwell	10,433	702	1,368	8,249	114	2,327	255	347	1,685	41
Camden	1,400	83	185	1,117	15	415	53	46	311	4
Carteret	10,498	609	1,395	8,372	121	2,715	301	365	2,022	27
Caswell	3,693	227	495	2,919	52	1,017	122	136	734	25
Catawba	12,429	870	1,678	9,751	130	2,422	308	346	1,730	38
Chatham	6,342	446	807	5,005	84	1,215	164	161	862	28
Cherokee	3,270	174	453	2,587	57	1,585	135	235	1,191	25
Chowan	2,226	158	360	1,675	34	761	95	134	521	10
Clay	1,274	59	173	1,017	26	511	44	67	389	12
Cleveland	12,589	921	1,753	9,765	150	2,672	350	423	1,851	48
Columbus	7,775	489	1,239	5,941	106	3,765	438	611	2,658	59
Craven	15,515	1,219	2,345	11,807	144	3,319	498	617	2,168	36
Cumberland	38,880	3,174	5,962	29,535	209	13,685	1,981	2,397	9,227	80
Currituck	3,123	217	452	2,424	30	535	44	102	383	7
Dare	4,829	301	603	3,880	45	967	70	97	790	9
Davidson	14,291	966	1,962	11,196	167	4,325	517	641	3,098	69
Davie	3,132	200	391	2,490	50	758	74	70	590	24
Duplin	6,236	428	927	4,802	79	2,477	305	348	1,788	35
Durham	20,057	1,432	2,497	15,966	161	5,653	711	691	4,204	48
Edgecombe	8,331	614	1,359	6,270	88	3,100	481	559	2,023	37
Forsyth	28,923	2,033	3,953	22,634	303	7,870	1,042	1,218	5,517	93
Franklin	4,933	326	719	3,824	64	1,853	201	287	1,333	33
Gaston	18,495	1,382	2,675	14,232	206	5,640	807	894	3,859	81
Gates	2,015	142	305	1,545	24	486	59	84	335	7
Graham	1,208	71	170	950	17	826	111	111	595	9
Granville	6,443	437	875	5,064	67	1,366	134	235	973	25
Greene	2,652	167	396	2,060	29	839	101	166	561	12
Guilford	38,940	2,633	4,943	30,976	388	10,875	1,363	1,386	8,011	115
Halifax	9,214	653	1,513	6,936	112	4,240	628	785	2,783	43
Harnett	12,877	944	1,839	9,965	129	4,371	559	642	3,118	52
Haywood	7,679	444	917	6,188	128	2,310	274	243	1,753	41
Henderson	10,900	654	1,406	8,642	199	2,626	345	368	1,874	39
Hertford	3,644	245	627	2,727	46	1,687	231	345	1,093	19
Hoke	3,651	292	617	2,714	28	1,280	182	262	826	11
Hyde	1,062	68	164	816	14	454	46	92	311	5
Iredell	14,855	1,093	2,020	11,576	166	2,790	353	415	1,974	48
Jackson	4,756	235	519	3,946	56	1,789	150	162	1,455	22

Average Daily Uninsured provides the estimated average daily number of persons without any health insurance coverage. The uninsured include those without Medicaid, Medicare, CHAMPUS, employer-provided group health insurance or individually purchased health insurance.

	TOTAL UNINSURED					UNINSURED BELOW POVERTY				
	Total	Under 6	6 to 17	18 to 64	65 +	Total	Under 6	6 to 17	18 to 64	65 +
Johnston	14,566	1,074	1,981	11,339	171	4,029	593	540	2,818	78
Jones	1,629	121	238	1,250	20	670	91	93	478	8
Lee	6,661	477	1,013	5,095	75	1,994	319	313	1,338	24
Lenoir	8,102	537	1,191	6,278	96	2,462	302	448	1,678	33
Lincoln	5,970	425	869	4,610	66	1,710	215	293	1,175	27
Macon	3,673	190	426	2,977	81	1,375	89	113	1,139	34
Madison	2,506	133	310	2,018	45	1,069	99	119	825	25
Martin	3,161	211	478	2,428	44	1,348	112	207	1,008	21
McDowell	6,587	403	930	5,172	81	1,699	302	375	999	23
Mecklenburg	61,101	4,581	8,409	47,658	452	15,672	2,134	2,283	11,126	130
Mitchell	2,294	126	299	1,825	43	758	76	94	566	21
Montgomery	3,393	250	514	2,590	39	955	124	175	642	14
Moore	9,284	616	1,332	7,167	169	2,015	277	353	1,349	36
Nash	12,010	844	1,735	9,303	129	3,016	412	466	2,090	47
New Hanover	15,384	959	2,027	12,246	153	6,796	794	895	5,054	52
Northhampton	3,643	227	554	2,808	54	1,360	160	249	931	21
Onslow	25,088	1,925	3,132	19,938	92	6,415	851	876	4,658	30
Orange	13,544	622	1,244	11,596	82	5,808	260	302	5,220	25
Pamlico	2,109	120	288	1,670	32	764	69	102	582	11
Pasquotank	5,728	427	951	4,286	64	1,825	258	339	1,209	20
Pender	5,681	401	793	4,419	69	1,889	287	299	1,278	25
Perquimans	1,932	110	302	1,490	30	700	92	136	462	9
Person	4,604	331	644	3,572	57	1,084	133	190	741	20
Pitt	13,670	827	1,815	10,909	119	8,573	850	1,049	6,606	68
Polk	2,399	156	285	1,904	53	469	45	50	359	14
Randolph	11,840	826	1,634	9,243	137	3,082	372	439	2,217	54
Richmond	6,574	483	1,045	4,962	84	2,196	300	413	1,451	33
Robeson	16,429	1,264	2,870	12,139	155	7,502	1,171	1,389	4,868	74
Rockingham	12,672	836	1,731	9,941	164	3,186	401	476	2,251	57
Rowan	12,026	848	1,758	9,255	165	3,194	372	501	2,264	58
Rutherford	8,076	566	1,164	6,230	115	2,027	250	319	1,415	43
Sampson	7,656	506	1,165	5,883	102	3,074	363	487	2,177	48
Scotland	5,000	376	835	3,743	47	1,770	316	315	1,121	18
Stanly	7,933	598	1,185	6,049	101	1,775	230	326	1,186	33
Stokes	4,931	306	670	3,891	65	1,144	96	186	829	34
Surry	8,857	581	1,151	7,000	124	2,014	193	276	1,498	47
Swain	1,757	108	260	1,364	25	1,220	151	166	890	14
Transylvania	4,009	237	531	3,175	65	1,230	165	170	879	17
Tyrrell	773	44	137	579	12	343	36	68	234	6
Union	10,342	836	1,587	7,827	92	2,250	321	391	1,501	36
Vance	5,777	434	894	4,387	63	2,213	304	374	1,511	24
Wake	55,962	3,875	6,855	44,884	349	14,044	1,427	1,488	11,018	111
Warren	3,059	185	473	2,350	51	1,532	180	255	1,074	24
Washington	2,572	180	410	1,950	31	862	139	155	556	12
Watauga	6,716	209	473	5,983	51	4,202	142	123	3,915	22
Wayne	18,094	1,286	2,648	14,001	159	4,503	574	800	3,070	58
Wilkes	8,765	513	1,150	6,986	117	2,365	222	291	1,798	54
Wilson	10,243	662	1,622	7,845	113	3,817	507	720	2,546	44
Yadkin	3,615	231	483	2,840	61	1,163	141	170	820	32
Yancey	2,459	142	315	1,959	42	995	76	133	765	21
STATE TOTAL	917,956	63,099	127,160	717,828	9,869	280,028	34,387	41,088	200,961	3,592

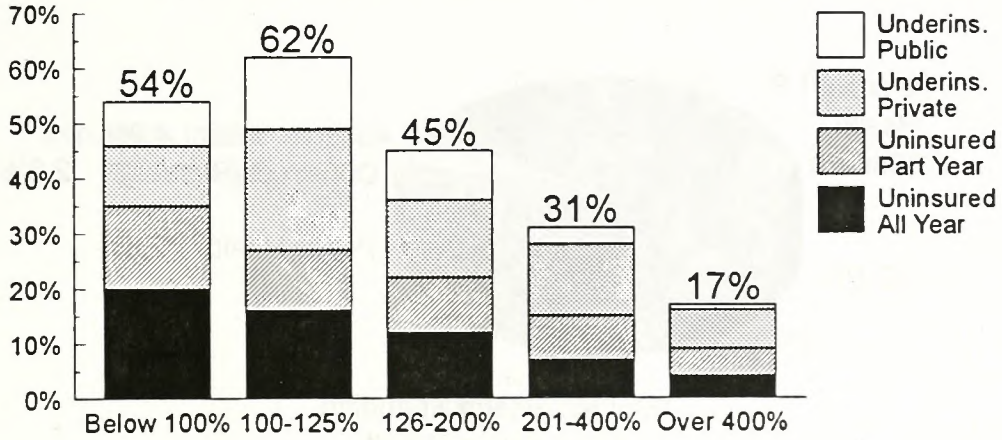
Numbers of Uninsured and Underinsured are Growing



Source: Duke University, Center for Health Policy Research &Education

Risk of Inadequate Coverage Highest Among Low Income

Percent With Inadequate Coverage, NC, 1995

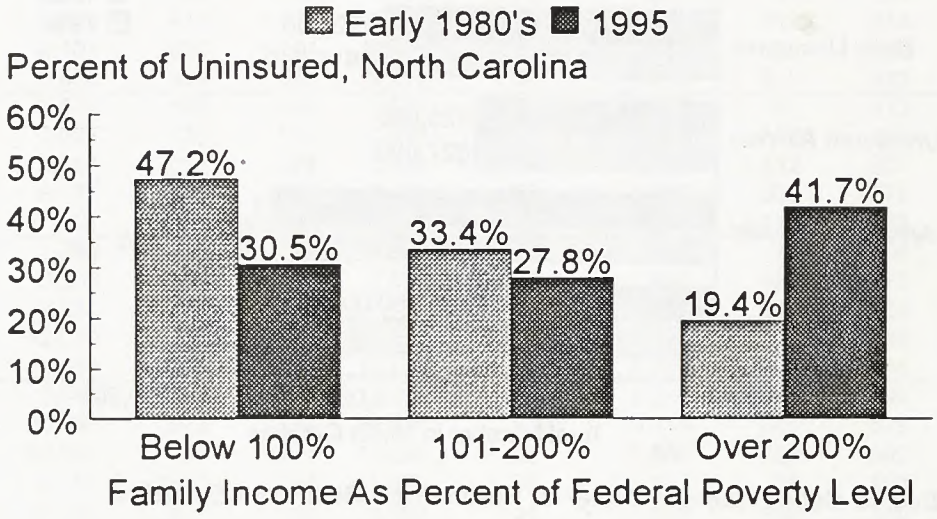


Family Income As Percent of Federal Poverty Level

Source: Duke University, Center for Health Policy Research & Education

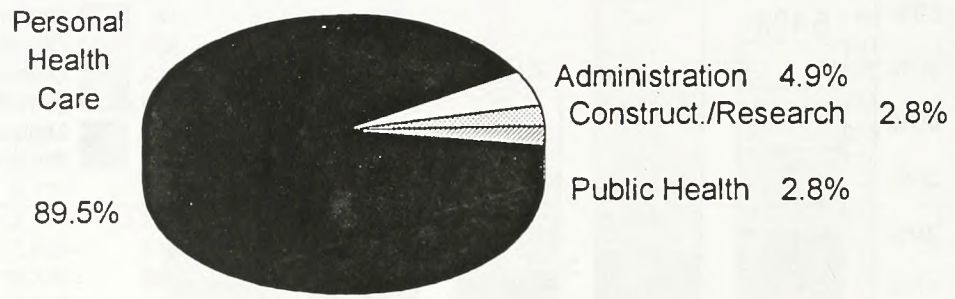
Source: Chris Conover, Duke University Center for Health Policy Research & Education (684-8026)

Uninsured Problem is Moving from the Poor into Middle Class



Source: Duke University, Center for Health Policy Research & Education

How North Carolina Spends Its Health Care Dollar

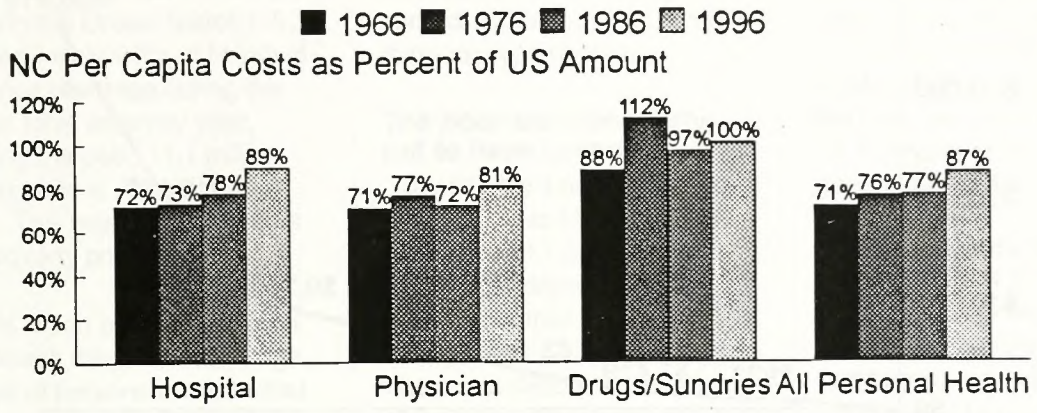


Total NC Health Spending
$24.3 Billion (1996)

Source: Duke University, Center for Health Policy Research & Education

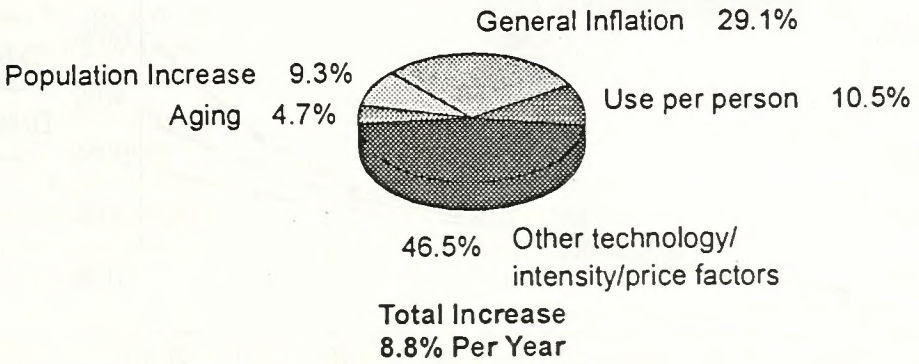
Source: Chris Conover, Duke University Center for Health Policy Research & Education (684-8026)

North Carolina Margin of Advantage is Shrinking



Source: Estimates developed by Duke University, Center for Health Policy Research & Education based on HCFA data

Projected Growth in Health Spending, U.S., 1995-2000

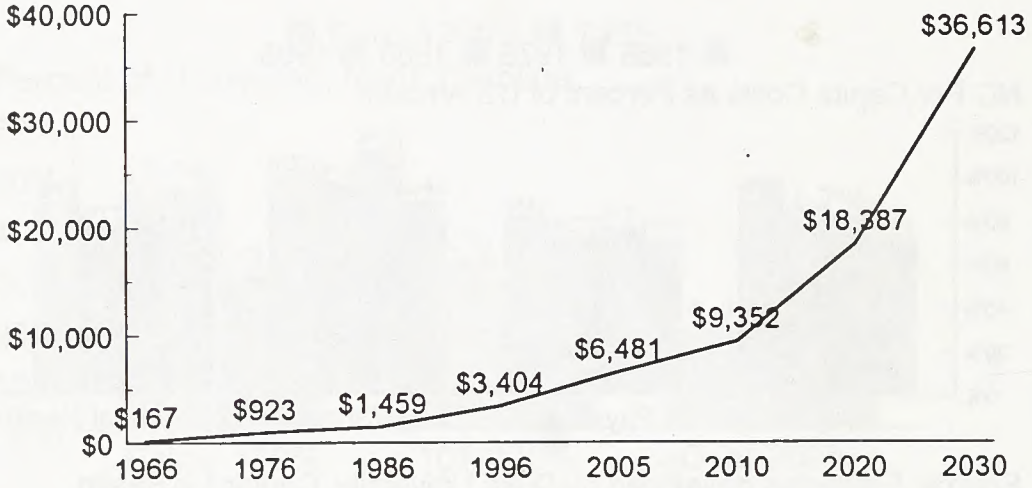


Source: CBO, 1993

Source: Chris Conover, Duke University Center for Health Policy Research & Education (684-8026)

Health Spending in North Carolina Is Escalating Dramatically

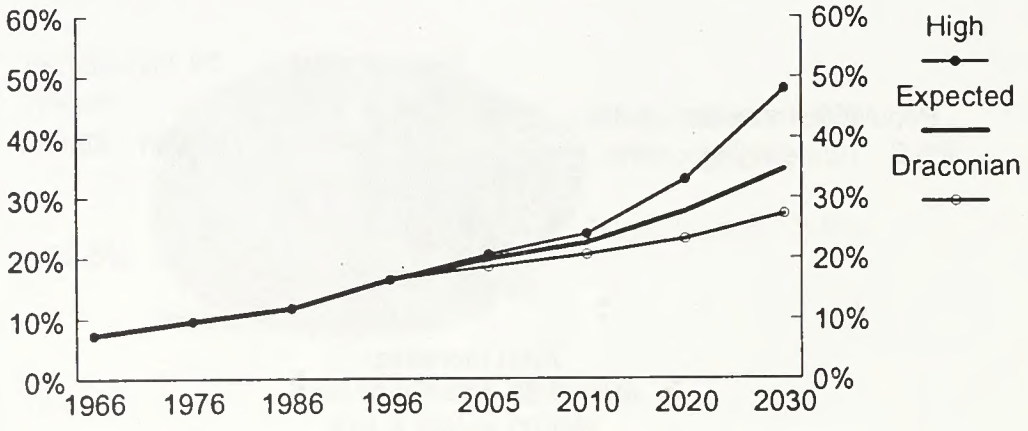
Per Capita Health Costs, North Carolina



Source: Duke University, Center for Health Policy Research & Education
Based on HCFA historical data and projections

Health Care is Absorbing An Increasing Share of Income

Total NC Health Expenditures As Percent of Personal Income



Source: Duke University, Center for Health Policy Research & Education
Based on HCFA historical data and projections

Source: Chris Conover, Duke University Center for Health Policy Research & Education (684-8026)

Current Population Reports; Household Economic Studies

CENSUS BUREAU

P60-190
November 1995

Health Insurance Coverage: 1994

By Robert L. Bennefield

An estimated 39.7 million persons in the United States (15.2 percent) were without health insurance coverage during the entire 1994 calendar year. Among the poor, 11.1 million persons were without coverage. This was 29.1 percent of the poverty population.

This report presents data on the health insurance coverage status of persons in the United States during the 1994 calendar year. The data, which are shown by selected demographic and socioeconomic characteristics, as well as by State, were collected by the March 1995 Supplement to the Current Population Survey (CPS). The CPS is a monthly nationwide survey of about 60,000 households conducted by the Census Bureau.

Employers are the leading providers.

As figure 1 shows, the majority of persons (70.3 percent) were covered by a private insurance plan for some or all of 1994. A private plan is one that was offered through an employer (either one's own or a relative's) or privately purchased. Most private insurance was obtained through a current or former employer or union (group health).

The remaining insured persons had government coverage. This includes Medicaid (12.1 percent), Medicare (12.9) percent, and military health care (4.3 percent). Many persons carry coverage from more than one type of plan.

The poor are more likely not to have coverage.

Despite the existence of programs such as Medicaid and Medicare, 29.1 percent of the poor (11.1 million) had no health insurance of any kind during 1994. This percentage was about double the rate for all persons. Poor persons comprised 27.8 percent of all uninsured persons.

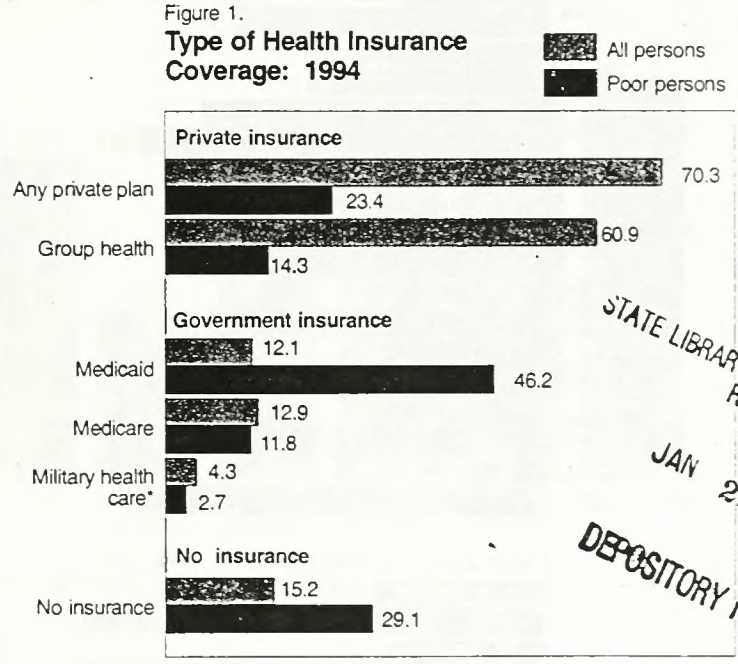
As figure 1 shows, Medicaid was the most widespread type of coverage among the poor. About 46.2 percent of poor persons were covered by Medicaid at some time during the year, compared with 12.1 percent of the general population.

Some are more likely than others to lack coverage.

As figure 2 shows, there were several key factors that influenced the chances of lacking coverage. They included—

- Age – Young adults aged 18 to 24 were more likely than other age groups to lack coverage during all of 1994 (26.7

Figure 1.
Type of Health Insurance Coverage: 1994

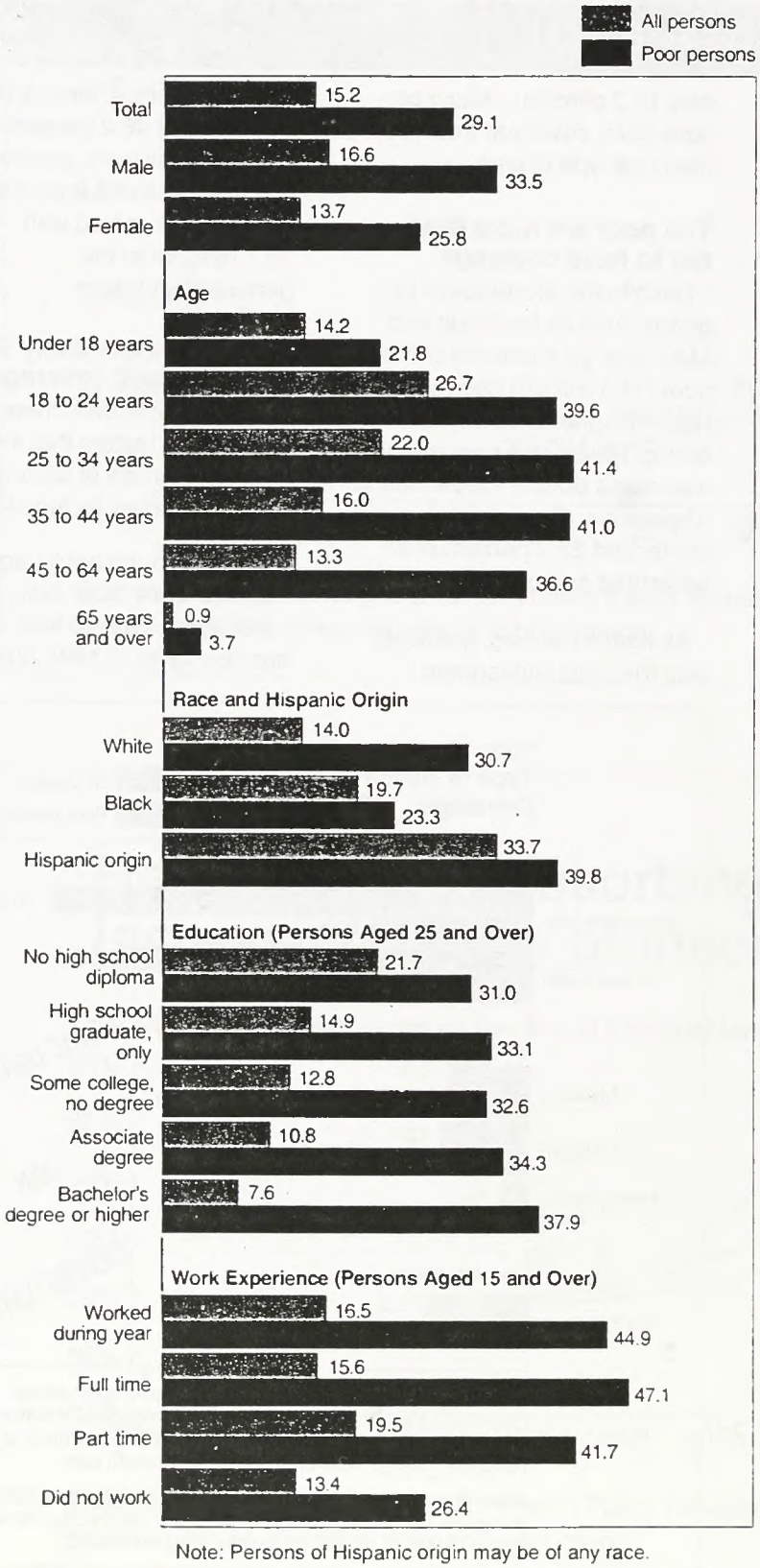


*Miltary health care inciudes CHAMPUS (Comprehensive Health and Medical Plan for Uniformed Services), CHAMPVA (Civilian Health and Medical Program of the Department of Veteran's Affairs), Veteran's and military health care.

Note: The percentages by type of coverage are not mutually exclusive; in other words, persons can be covered by more than one type of health insurance during the year.

Figure 2.
Who Lacked Coverage?

Percent of all persons (and poor persons) not covered by health insurance at any time during the year, by selected characteristics: 1994



Note: Persons of Hispanic origin may be of any race.

percent). The elderly were at the other extreme (0.9 percent). Among the poor, adults aged 18 to 64 had much higher noncoverage rates than either children or the elderly.

- Race and Hispanic origin – Among poor and all persons alike, those of Hispanic origin had the highest chance of lacking coverage.

- Educational attainment – Among all adults, the likelihood of being uninsured declined as the level of education rose. Among the poor, however, there were no significant differences across the education groups.

- Work experience – Overall, part-time workers had the highest noncoverage rate (19.5 percent). These workers were adults aged 15 or over who worked less than 35 hours per week in the majority of the weeks they worked in 1994. Thanks to Medicare coverage of the elderly and the Medicaid "safety net," nonworkers had the lowest rate (13.4 percent).

Among the poor, workers had a far higher uninsured rate than nonworkers.

Income and firm size play roles.

Figure 3 shows noncoverage rates by household income. In general, as household income rose, noncoverage rates fell.

Of the 139.1 million workers, 53.3 percent had employer-provided health insurance policies in their own name. The proportion varied by size of employer, with workers employed by small firms (less than 25 people) being less likely to have employer-provided health insurance policies in their own name. (See figure 4.)

States show differences in noncoverage rates.

Percentages of persons without health insurance coverage ranged from 8.4 percent in North Dakota to 24.2 percent in Texas. However, we advise against using these estimates to rank the States. Results from different samples could easily show different estimates and rankings because of small sample sizes. For example, the high noncoverage rate for Texas was not statistically different from that in New Mexico (23.1 percent), while the rates for Vermont, Wisconsin, Hawaii, Minnesota, Iowa, South Dakota, Tennessee, Connecticut, Indiana, and Nebraska were not statistically different from North Dakota.

Figure 3.

As Income Rises, Chances of Having No Insurance Generally Decline

Percent of all persons not covered by health insurance at any time during the year, by household income: 1994

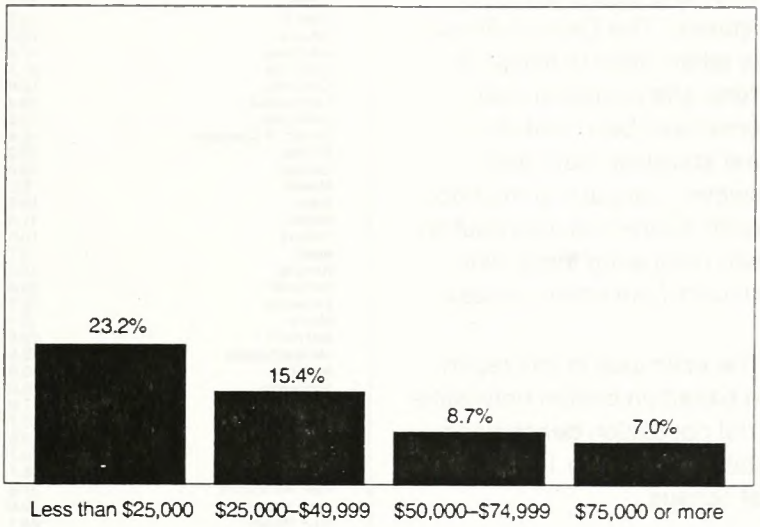
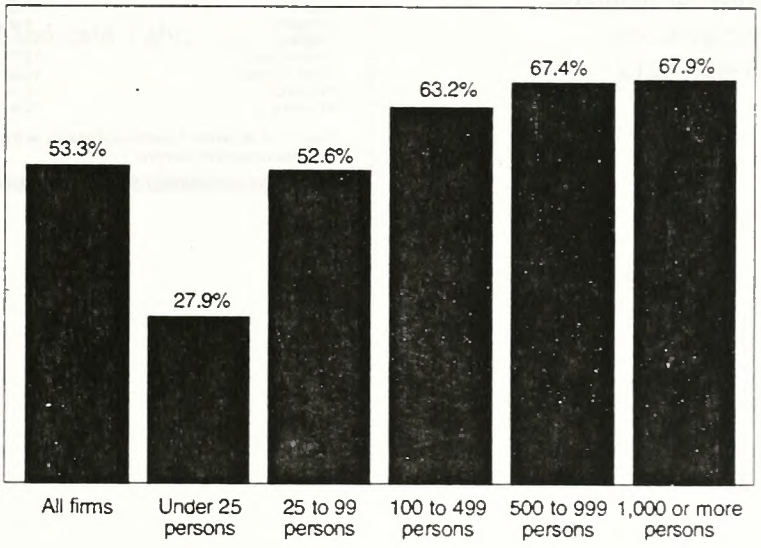


Figure 4.

Workers in Large Firms Are the Most Likely to Have Employer-Provided Insurance

Percent of workers (aged 15 and over) with employer-provided health insurance policies in their own name, by size of firm they worked for: 1994



A Note About the Estimates

The introduction of a computer-assisted CPS questionnaire in 1994 provided the Census Bureau with an opportunity to clarify the questions used to measure the extent to which persons are covered by health insurance. In the past, underreporting of health insurance coverage in the CPS had been a persistent problem, as other surveys (such as the Survey of Income and Program Participation) have shown consistently higher annual coverage rates. The revised questions were successful in that they appear to result in improved reporting of health insurance coverage (and of employer-provided coverage, in particular). This improved reporting, however, makes time series comparisons difficult to interpret. For that reason, this report focuses on comparisons between groups rather than over time. The Census Bureau is currently working on a document, to be released later this year, that explains the questionnaire changes in detail and their estimated effect on CPS health insurance estimates.

Accuracy of the Estimates

All statistics in the report are subject to sampling variability, as well as survey design flaws, respondent classification errors, and data processing mistakes. The Census Bureau has taken steps to minimize errors, and analytical statements have been tested and meet statistical standards. However, because of methodological differences, use caution when comparing these data with data from other sources.

The estimates in this report are based on civilian noninstitutional population benchmarks established by the 1990 decennial census.

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Thomas Moore
301-457-4215

Figure 4.

Percent of Persons Not Covered by Health Insurance, by State: 1994

State	Percent	Standard error	90-percent confidence interval
Alabama	19.2	1.4	16.9 – 21.5
Alaska	13.3	1.1	11.5 – 15.1
Arizona	20.2	1.4	17.9 – 22.5
Arkansas	17.4	1.4	15.1 – 19.7
California	21.1	0.6	20.1 – 22.1
Colorado	12.4	1.2	10.4 – 14.4
Connecticut	10.4	1.3	8.3 – 12.5
Delaware	13.5	1.4	11.2 – 15.8
District of Columbia	16.4	1.6	13.8 – 19.0
Florida	17.2	0.7	16.0 – 18.4
Georgia	16.2	1.3	14.1 – 18.3
Hawaii	9.2	1.1	7.4 – 11.0
Idaho	14.0	1.1	12.2 – 15.8
Illinois	11.4	0.6	10.4 – 12.4
Indiana	10.5	1.1	8.7 – 12.3
Iowa	9.7	1.1	7.9 – 11.5
Kansas	12.9	1.2	10.9 – 14.9
Kentucky	15.2	1.3	13.1 – 17.3
Louisiana	19.2	1.5	16.7 – 21.7
Maine	13.1	1.3	11.0 – 15.2
Maryland	12.6	1.3	10.5 – 14.7
Massachusetts	12.5	0.7	11.3 – 13.7
Michigan	10.8	0.6	9.8 – 11.8
Minnesota	9.5	1.1	7.7 – 11.3
Mississippi	17.8	1.3	15.7 – 19.9
Missouri	12.2	1.3	10.1 – 14.3
Montana	13.6	1.2	11.6 – 15.6
Nebraska	10.7	1.1	8.9 – 12.5
Nevada	15.7	1.2	13.7 – 17.7
New Hampshire	11.9	1.4	9.6 – 14.2
New Jersey	13.0	0.6	12.0 – 14.0
New Mexico	23.1	1.4	20.8 – 25.4
New York	16.0	0.5	15.2 – 16.8
North Carolina	13.3	0.6	12.3 – 14.3
North Dakota	8.4	1.0	6.8 – 10.0
Ohio	11.0	0.6	10.0 – 12.0
Oklahoma	17.8	1.4	15.5 – 20.1
Oregon	13.1	1.3	11.0 – 15.2
Pennsylvania	10.6	0.6	9.6 – 11.6
Rhode Island	11.5	1.3	9.4 – 13.6
South Carolina	14.2	1.1	12.4 – 16.0
South Dakota	10.0	1.0	8.4 – 11.6
Tennessee	10.2	1.0	8.6 – 11.8
Texas	24.2	0.8	22.9 – 25.5
Utah	11.5	1.1	9.7 – 13.3
Vermont	8.6	1.1	6.8 – 10.4
Virginia	12.0	1.0	10.4 – 13.6
Washington	12.7	1.2	10.7 – 14.7
West Virginia	16.2	1.4	13.9 – 18.5
Wisconsin	8.9	1.0	7.3 – 10.5
Wyoming	15.4	1.5	12.9 – 17.9

Note: The 90-percent confidence interval is the range in which estimates would fall from 90 percent of all possible household samples.

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Appendix G

Medicaid Tables and Charts

DRAFT

Table 1
State Fiscal Year 1995
Federal Matching Rates

Benefit Costs
(7/1/94 - 9/30/94)

	Family Planning		All Other
Federal	90.0%	Federal	65.14%
State	8.5%	State	29.63%
County	1.5%	County	5.23%

Benefit Costs
10/1/94 - 6/30/95)

	Family Planning		All Other
Federal	90.0%	Federal	64.71%
State	8.5%	State	29.99%
County	1.5%	County	5.30%

Administrative Costs
(7/1/94 - 6/30/95)

	Skilled Medical Personnel & MMIS*	All Other
Federal	75.0%	50.00%
Non-Federal	25.0%	50.00%

*MMIS-Medicaid Management Information System

Table 2
State Fiscal Year 1995
Medicaid Financial Eligibility Standards

Eligibility Income Levels
(Annual)

Family Size	* AFDC Related * Groups: Categorically Needy	* AFDC Related * Groups: Medically Needy	Aged, Blind & Disabled: All Groups	Pregnant Women Infants < 1 Yr 185% of Poverty	Children Ages 1-5 133% of Poverty	Children Age 6 & Over 100% of Poverty	Qualified Medicare Beneficiaries 100% of Poverty	Specified Low-Income Medicare Beneficiaries 101-120% of Poverty	"Spousal Impoverishment" Beneficiaries 150% of Poverty	Qualified Disabled Working Individual 200% of Poverty
1	4,344	2,904	2,904	13,824	9,936	7,476	7,476	7,476 - 8,964	Minimum of $15,048	14,952
2	5,664	3,804	3,804	18,564	13,344	10,032	10,032	10032 - 12036	up to a Maximum of	20,064
3	6,528	4,404	N/A	23,292	16,752	12,600			$22,452	
4	7,128	4,800	N/A	28,032	20,160	15,156				
5	7,776	5,196	N/A	32,772	23,556	17,712				
Eligibility Resource Limits										
1	$1,000	$1,500	$2,000	NO RESOURCE TEST			$4,000	$4,000	$14,964 minimum	$4,000
2	No increment	2,250	3,000	APPLIES			6,000	6,000	$72,820 maximum	6,000
3	for family size	2,350	N/A							
4		2,450	N/A							
5		2,550	N/A							

Source: Income & Reserve Levels (REV. 6/95)

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Table 3
State Fiscal Years 1994 & 1995
Enrolled Medicaid Providers

Numbers	SFY 1994	SFY 1995
Physicians*	22,103	23,929
Dentists	3,007	3,098
Pharmacists	2,371	2,345
Optometrists	994	1,026
Chiropractors	722	801
Podiatrists	335	361
Ambulance Companies	238	261
Home Health Agencies**	155	160
Durable Medical Equip. Suppliers	266	138
Intermediate Care Facilities-MR	288	309
Hospitals	194	194
Mental Health Clinics	136	151
Nursing Facilities	365	417
Optical Supplies Company***	1	1
Personal Care Agencies	251	342
Rural Health Clinics	68	96
Nurse Midwives	18	19
Hospices	62	64
CAP Providers	459	351
Other Clinics	92	58
Other	2,124	3,894
Total	**34,249**	**38,015**

* The count of physicians reflects each provider number assigned to an individual physician or a group practice of physicians. Most physicians practicing in a group practice have an individual provider number in addition to the group number. Also physicians who practice in multiple settings are included once for each practice setting.

**Includes physical, speech and occupational therapies and home infusion therapy services

***Single source purchase contract effective October 1, 1990.

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Table 4
State Fiscal Year 1995
Medicaid Services

1 Ambulance Transportation
2 Case Management for:
- Pregnant women
- High risk children (0-5)
- Chronically mentally ill adults
- Emotionally disturbed children
- Chronic substance abusers
- Adults & Children at risk of abuse, neglect, or exploitation
- Persons with HIV Disease

3 Chiropractors
4 Clinic Services
5 Community Alternatives Programs (CAP)
6 Dental Care Services
7 Durable Medical Equipment
8 Health Check Services (EPSDT)
9 Family Planning Services
10 Hearing Aids (for children)
11 Home Health Services
12 Home Infusion Therapy Services
13 Hospice
14 Inpatient & Outpatient Hospital Services
15 Intermediate Care Facilities for the Mentally Retarded (ICF-MR)
16 Laboratory & X-Ray Services
17 Mental Hospitals (age 65 & over)
18 Migrant Health Clinics
19 Nurse Midwives
20 Nurse Practitioners
21 Nursing Facilities (NF)
22 Optical Supplies
23 Optometrists
24 Personal Care Services
25 Physicians
26 Podiatrists
27 Prepaid Health Plan Services
28 Prescription Drugs
29 Private Duty Nursing Services
30 Prosthetics and Orthotics (children)
31 Rehabilitative Services:
(under the auspices of area mental health programs)
32 Rural Health Clinics
33 Specialty Hospitals
34 Transportation

Table 5
State Fiscal Year 1994 & 1995
Sources of Medicaid Funds

	1994	1995
Federal	$ 2,105,307,078	$ 2,221,867,100
State Appropriated	$ 788,493,250	$ 942,583,866
State, Other	$ 489,380,613	$ 198,086,742
County	$ 166,918,436	$ 187,930,522
Total	**$ 3,550,099,377**	**$ 3,550,468,230**

Source: DAS report

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Table 6
State Fiscal Year 1995
Uses of Medicaid Funds

Type of Service	Total Expenditures	Percent of Total Dollars	Percent of Service Dollar	Users of Services*	Cost Per Service Use
Inpatient Hospital	602,289,541	17.0%	19.5%	185,746	3,243
Outpatient Hospital	197,350,933	5.6%	6.4%	518,071	381
Mental Hospital >65 & <21	30,684,349	0.9%	1.0%	2,340	13,113
Physician	308,497,976	8.7%	10.0%	859,156	359
Clinics	142,276,713	4.0%	4.6%	212,072	671
Nursing Facility (Skilled)	355,761,200	10.0%	11.5%	27,172	13,093
Nursing Facility (Intermediate)	322,671,839	9.1%	10.4%	23,365	13,810
ICF-MR	339,722,311	9.6%	11.0%	4,970	68,355
Dental	37,814,255	1.1%	1.2%	223,101	169
Prescription Drugs	254,399,563	7.2%	8.2%	727,931	349
Home Health	92,538,103	2.6%	3.0%	48,699	1,900
Other Services	267,225,022	7.5%	8.6%	1,386,229	193
Medicare Premiums:					
(Part A, Part B, QMB, Dually Eli	131,245,574	3.7%	4.2%		
HMO Premium	8,618,565	0.2%	0.3%		
Subtotal Services	**3,091,095,944**				
Adjustments & Cost Settlements	93,044,363	2.6%			
Disproportionate Share Payments	242,192,743	6.8% **			
Subtotal Services & Other	**$ 3,426,333,050**	**96.5%**			
Administration (State & County)	124,135,180	3.5%			
(State)	53,857,082	1.5%			
(County)	70,278,098	2.0%			
Grand Total Expenditures	**$ 3,550,468,230**	**100.0%**			
Total Recipients (unduplicated)***				1,068,939	
Total Expenditures Per Recipient (unduplicated)					$ 3,321

* "Users of Service" is a duplicated count. Recipients using one or more services are counted in each service category.

** Additional payments for hospitals providing services to a higher than average number of Medicaid patients.

*** "Total Recipients" is unduplicated, counting recipients only once during the year regardless of the number or type of services they use.

NOTE: Numbers may not add due to rounding.
SOURCE: SFY 1995-2082 report, SFY 1995-DAS report, SFY 1995-PER report

Table 7
SFY 1979-1995
A History of Medicaid Expenditures

Fiscal Year	Expenditures	Percentage Change
1979	$ 379,769,848	N/A
1980	410,053,625	8%
1981	507,602,694	24%
1982	521,462,961	3%
1983	570,309,294	9%
1984	657,763,927	15%
1985	665,526,678	1%
1986	758,115,890	14%
1987	861,175,819	14%
1988	983,464,113	14%
1989	1,196,905,351	22%
1990	1,427,672,567	19%
1991	1,942,016,092	36%
1992	2,478,709,587	28%
1993	2,836,335,468	14%
1994	3,550,099,377	25%
1995	3,550,468,230	0%

NOTE: Include vendor payments, Administrative costs, Refunds, adjustments, & Disproportionate share hospital payments.

SOURCE: DAS Report - SFY

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State Fiscal Years 1979-1995
A History of Medicaid Eligibles

Fiscal Years	Aged	Qualified Medicare Beneficiaries	Blind	Disabled	AFDC Adults & Children	Medicaid Pregnant Women Coverage	Medicaid Indigent Children Coverage	Other Children	Aliens and Refugees	Total
1978-79	82,930	N/A	3,219	59,187	301,218	N/A	N/A	6,620	N/A	453,174
1979-80	82,859	N/A	2,878	56,265	307,059	N/A	N/A	6,641	N/A	455,702
1980-81	80,725	N/A	2,656	56,773	315,651	N/A	N/A	6,559	N/A	459,364
1981-82	70,010	N/A	2,349	48,266	298,483	N/A	N/A	6,125	N/A	425,233
1982-83	67,330	N/A	2,000	46,537	293,623	N/A	N/A	6,062	N/A	415,552
1983-84	65,203	N/A	1,755	46,728	288,619	N/A	N/A	5,501	N/A	407,806
1984-85	65,849	N/A	1,634	48,349	293,188	N/A	N/A	5,333	N/A	414,353
1985-86	69,193	N/A	1,554	51,959	313,909	N/A	N/A	5,315	N/A	441,930
1986-87	72,295	N/A	1,462	54,924	317,983	N/A	N/A	5,361	N/A	452,025
1987-88	76,308	N/A	1,394	58,258	323,418	9,842	6,543	5,563	N/A	481,326
1988-89	80,044	19,064	1,304	62,419	352,321	20,277	19,615	6,009	561	561,614
1989-90	80,266	33,929	1,220	64,875	387,882	28,563	36,429	5,176	1,011	639,351
1990-91	81,466	42,949	1,116	70,397	451,983	37,200	61,210	4,296	1,675	753,292
1991-92	83,337	56,871	1,064	79,282	513,023	43,330	94,922	4,139	1,955	877,923
1992-93	85,702	71,120	1,003	87,664	562,661	45,629	132,348	4,133	2,437	992,697
1993-94	86,111	83,460	929	90,889	581,397	46,970	162,417	4,100	2,330	1,058,603
1994-95	127,514	48,373	2,716	155,215	533,300	48,115	216,888	3,808	2,857	1,138,786
SFY 1994 Percent Total Eligibles:	8.1%	7.9%	0.1%	8.6%	54.9%	4.4%	15.3%	0.4%	0.2%	100.0%
SFY 1995 Percent Total Eligibles:	11.2%	4.2%	0.2%	13.6%	46.8%	4.2%	19.0%	0.3%	0.3%	100.0%

* Aged, QMB, Blind, Disabled are adjusted figures for 1995.

Source: Medicaid Eligibilty Report, SFY 1994, SFY 1995

Table 9
State Fiscal Year 1995
Total Expenditures and Eligibles by County

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COUNTY NAME	1994 EST. COUNTY POPULATION	NUMBER OF MEDICAID ELIGIBLES	TOTAL EXPENDITURES	EXPENDITURE PER ELIGIBLE	PER CAPITA EXPENDITURE AMOUNT	PER CAPITA EXPENDITURE RANKING	ELIGIBLES PER 1,000 POPULATION	% of Eligibles on Medicaid by county, based on 1994 population (Column C / Column B)
ALAMANCE	113,670	14,353	$ 46,685,762	$ 3,253	$ 410.71	74	126	12.63%
ALEXANDER	29,649	3,791	10,361,350	2,733	349.47	87	128	12.79%
ALLEGHANY	9,610	1,448	5,357,714	3,700	557.51	39	151	15.07%
ANSON	24,009	5,955	18,351,372	3,082	764.35	9	248	24.80%
ASHE	22,924	4,102	14,088,218	3,434	614.56	27	179	17.89%
AVERY	15,070	2,765	10,549,307	3,815	700.02	15	183	18.35%
BEAUFORT	43,237	9,757	26,645,175	2,731	616.26	26	226	22.57%
BERTIE	20,498	6,139	15,996,638	2,606	780.40	7	299	29.95%
BLADEN	29,478	8,106	22,651,030	2,794	768.40	8	275	27.50%
BRUNSWICK	58,518	11,406	32,903,068	2,885	562.27	38	195	19.49%
BUNCOMBE	185,810	28,006	85,588,045	3,056	460.62	60	151	15.07%
BURKE	79,646	11,626	36,232,179	3,116	454.92	63	146	14.60%
CABARRUS	107,216	13,227	42,259,968	3,195	394.16	79	123	12.34%
CALDWELL	73,079	10,579	35,138,523	3,322	480.83	55	145	14.48%
CAMDEN	6,221	982	2,554,993	2,602	410.70	75	158	15.79%
CARTERET	56,624	8,223	23,484,687	2,856	414.75	73	145	14.52%
CASWELL	21,221	3,923	11,452,541	2,919	539.68	43	185	18.49%
CATAWBA	123,913	15,553	42,207,254	2,714	340.62	91	126	12.55%
CHATHAM	41,959	4,840	16,900,924	3,492	402.80	76	115	11.54%
CHEROKEE	21,452	4,862	13,702,146	2,818	638.74	23	227	22.66%
CHOWAN	13,993	3,527	9,605,049	2,723	686.42	18	252	25.21%
CLAY	7,564	1,419	4,168,946	2,938	551.16	40	188	18.76%
CLEVELAND	87,766	15,610	39,168,155	2,509	446.28	67	178	17.79%
COLUMBUS	51,000	15,783	41,961,414	2,659	822.77	2	309	30.95%
CRAVEN	84,410	15,278	38,813,968	2,541	459.83	61	181	18.10%
CUMBERLAND	291,849	46,731	90,497,720	1,937	310.08	95	160	16.01%
CURRITUCK	15,402	2,470	5,030,427	2,037	326.61	93	160	16.04%
DARE	24,804	2,570	7,808,396	3,038	314.80	94	104	10.36%
DAVIDSON	134,802	17,413	46,561,349	2,674	345.41	89	129	12.92%
DAVIE	29,336	3,104	10,543,569	3,397	359.41	85	106	10.58%
DUPLIN	41,990	9,890	25,317,030	2,560	602.93	31	236	23.55%
DURHAM	191,148	28,072	84,069,000	2,995	439.81	68	147	14.69%
EDGECOMBE	56,372	16,776	39,417,395	2,350	699.24	16	298	29.76%
FORSYTH	276,172	37,700	104,812,629	2,780	379.52	84	137	13.65%
FRANKLIN	40,417	7,541	24,683,497	3,273	610.72	29	187	18.66%
GASTON	177,902	28,510	82,283,777	2,886	462.52	59	160	16.03%
GATES	9,740	1,847	5,155,562	2,791	529.32	44	190	18.96%
GRAHAM	7,420	1,838	5,130,429	2,791	691.43	17	248	24.77%
GRANVILLE	40,479	6,213	19,289,025	3,105	476.52	56	153	15.35%
GREENE	16,396	3,321	9,312,962	2,804	568.00	34	203	20.25%
GUILFORD	365,572	49,979	141,674,595	2,835	387.54	61	137	13.67%
HALIFAX	57,183	18,158	40,438,783	2,227	707.18	13	318	31.75%
HARNETT	74,834	14,668	37,543,904	2,560	501.70	49	196	19.60%
HAYWOOD	49,051	8,214	24,100,750	2,934	491.34	51	167	16.75%
HENDERSON	75,096	10,775	32,216,286	2,990	429.00	71	143	14.35%
HERTFORD	22,430	7,192	17,759,021	2,469	791.75	4	321	32.06%
HOKE	26,618	6,662	14,554,481	2,185	546.79	41	250	25.03%
HYDE	5,270	1,516	4,220,722	2,784	800.90	3	288	28.77%
IREDELL	100,786	13,554	38,407,837	2,834	381.08	83	134	13.45%
JACKSON	28,414	4,744	13,431,826	2,831	472.72	57	167	16.70%
JOHNSTON	91,552	16,510	45,308,478	2,744	494.89	50	180	18.03%
JONES	9,498	2,233	7,111,152	3,185	748.70	10	235	23.51%

State Fiscal Year 1995 Cont'd
Total Expenditures and Eligibles by County

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COUNTY NAME	1994 EST. COUNTY POPULATION	NUMBER OF MEDICAID ELIGIBLES	TOTAL EXPENDITURES	EXPENDITURE PER ELIGIBLE	PER CAPITA EXPENDITURE AMOUNT	PER CAPITA EXPENDITURE RANKING	ELIGIBLES PER 1,000 POPULATION	% of Eligibles on Medicaid by county, based on 1994 population (Column C / Column B)
LEE	44,818	8,250	20,333,307	2,465	453.69	65	184	18.41%
LENOIR	58,695	14,383	37,506,274	2,608	639.00	22	245	24.50%
LINCOLN	54,740	7,266	19,314,122	2,658	352.83	86	133	13.27%
MACON	36,727	4,298	11,209,388	2,608	305.21	96	117	11.70%
MADISON	25,471	3,741	11,899,023	3,181	467.16	58	147	14.69%
MARTIN	17,598	6,336	15,815,579	2,496	898.71	1	360	36.00%
MCDOWELL	26,058	5,583	15,642,557	2,802	600.30	32	214	21.43%
MECKLENBURG	561,223	75,190	194,865,220	2,592	347.22	88	134	13.40%
MITCHELL	14,458	2,475	8,735,173	3,529	604.18	30	171	17.12%
MONTGOMERY	23,684	5,410	12,535,560	2,317	529.28	45	228	22.84%
MOORE	64,969	9,176	25,689,460	2,800	395.41	78	141	14.12%
NASH	82,788	14,509	37,409,673	2,578	451.87	66	175	17.53%
NEW HANOVER	134,970	22,607	65,274,506	2,887	483.62	54	167	16.75%
NORTHAMPTON	20,611	6,505	16,308,183	2,507	791.24	5	316	31.56%
ONSLOW	147,144	18,275	37,179,504	2,034	252.67	100	124	12.42%
ORANGE	104,668	8,051	29,653,230	3,683	283.31	98	77	7.69%
PAMLICO	11,779	2,175	7,213,802	3,317	612.43	28	185	18.47%
PASQUOTANK	33,287	7,694	16,947,841	2,203	509.14	48	231	23.11%
PENDER	33,588	7,157	19,012,052	2,656	566.04	35	213	21.31%
PERQUIMANS	10,558	2,626	5,580,353	2,125	528.54	46	249	24.87%
PERSON	31,332	5,515	18,119,246	3,285	578.30	33	176	17.60%
PITT	116,088	23,079	65,483,877	2,837	564.09	37	199	19.88%
POLK	15,471	1,844	6,500,350	3,525	420.16	72	119	11.92%
RANDOLPH	112,926	13,960	38,753,538	2,776	343.18	90	124	12.36%
RICHMOND	45,041	10,971	30,432,588	2,774	675.66	19	244	24.36%
ROBESON	109,876	33,796	78,911,821	2,335	718.19	12	308	30.76%
ROCKINGHAM	87,672	14,502	43,066,717	2,970	491.23	52	165	16.54%
ROWAN	116,860	16,338	44,562,385	2,728	381.33	82	140	13.98%
RUTHERFORD	58,628	9,603	25,365,486	2,641	432.65	69	164	16.38%
SAMPSON	49,868	12,139	31,238,207	2,573	626.42	25	243	24.34%
SCOTLAND	34,630	10,053	23,020,993	2,290	664.77	20	290	29.03%
STANLY	53,727	7,959	23,095,434	2,902	429.87	70	148	14.81%
STOKES	40,152	5,061	15,602,078	3,083	388.58	80	126	12.60%
SURRY	64,348	9,338	29,350,656	3,143	456.12	62	145	14.51%
SWAIN	11,504	3,022	7,514,266	2,487	653.19	21	263	26.27%
TRANSYLVANIA	27,041	4,242	13,244,454	3,122	489.79	53	157	15.69%
TYRRELL	3,814	1,100	2,998,176	2,726	786.10	6	288	28.84%
UNION	94,352	12,651	31,583,108	2,496	334.74	92	134	13.41%
VANCE	39,892	11,132	28,035,620	2,518	702.79	14	279	27.91%
WAKE	496,578	46,475	136,222,019	2,931	274.32	99	94	9.36%
WARREN	17,866	4,605	13,174,050	2,861	737.38	11	258	25.78%
WASHINGTON	13,875	3,734	8,854,584	2,371	638.17	24	269	26.91%
WATAUGA	39,364	3,619	11,719,887	3,238	297.73	97	92	9.19%
WAYNE	109,083	20,168	49,621,616	2,460	454.90	64	185	18.49%
WILKES	61,257	9,365	31,679,496	3,383	517.16	47	153	15.29%
WILSON	67,464	16,115	38,110,539	2,365	564.90	36	239	23.89%
YADKIN	32,871	4,221	13,178,694	3,122	400.92	77	128	12.84%
YANCEY	15,986	3,011	8,642,290	2,870	540.62	42	188	18.84%
STATE TOTAL	**7,064,470**	**1,138,786**	**$3,099,716,010**	**$2,722**	**$438.78**	**N/A**	**161**	**16.12%**

Source: Medicaid Cost Calculation Fiscal Y-T-D June 1995.

Note: Data reflect only net vendor payments for which the county is billed for its computable share.

Table 10
State Fiscal Year 1995
Medicaid Service Expenditures by Eligibility Group

Eligibility Group	Total Service Dollars	Percent of Service Dollars	Total Recipients	Percent of Recipients	SFY 1995 Expenditures Per Recipient	SFY 1994 Expenditures Per Recipient	94/95 Percent Change
Total Elderly	**$ 1,048,569,874**	**34.0%**	**168,422**	**15.8%**	**$ 6,226**	**$ 5,455**	**14.1%**
Aged	974,262,525	31.6%	98,086	9.2%	9,933	8,890	11.7%
Medicare-Aid (MQBQ & MQBB)	74,307,349	2.4%	70,336	6.6%	1,056	668	58.2%
Total Disabled	**$ 1,020,752,494**	**33.1%**	**117,903**	**11.0%**	**8,658**	**8,630**	**0.3%**
Disabled	1,006,155,780	32.6%	116,585	10.9%	8,630	8,680	-0.6%
Blind	14,596,714	0.5%	1,318	0.1%	11,075	10,581	4.7%
Total Families & Children	**$ 1,022,760,078**	**33.2%**	**779,895**	**73.0%**	**1,311**	**1,340**	**-2.1%**
AFDC Adults (> 21)	285,715,108	9.3%	180,941	16.9%	1,579	1,482	6.5%
Medicaid Pregnamt Women Coverage	116,857,232	3.8%	66,390	6.2%	1,760	1,770	-0.6%
AFDC Children & Other Children	386,372,333	12.5%	337,117	31.5%	1,146	1,204	-4.8%
Medicaid Indigent Children	233,815,405	7.6%	195,447	18.3%	1,196	1,302	-8.1%
Aliens & Refugees	**$ 4,423,710**	**0.1%**	**2,687**	**0.3%**	**1,646**		
Adjustments Not Attributable To A Specific Category	**$ (13,997,978)**	**-0.5%**					
Total Service Expendatures All Groups	**$ 3,082,508,178**	**100%**	**1,068,907**	**100%**	**$ 2,884**	**$ 2,796**	**3.1%**

Note: Total Service Expenditures does not include:

Disproportionate Share payments	$242,192,743
State & county administrative costs	$124,135,180
Adjustments processed by DMA settlements	$93,964,447
HMO premiums	$8,618,565
TOTAL	$ 468,910,935

See Table 6 for more details.
Source: SFY 1995 Program Expenditure Report and 2082 Report.

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Table 11
State Fiscal Year 1995
Service Expenditure For Selected Major Medical Services By Program Category

Type of Service	Total	Percent of Service Dollars	Aged	MQBQ* Medicare Qualified Beneficiary	MQBB Part B Premium Only	Blind	Disabled	AFDC Adult**	AFDC Child***	Aliens & Refugees	Adjustments Unattributable To A Specific Category
Inpatient Hospital	$ 602,289,541	19.5%	$ 19,898,419	$ 8,102,342	$ -	$ 1,042,260	$ 225,205,561	$ 139,723,279	$ 211,964,455	$ 2,345,070	$ (5,991,845)
Outpatient Hospital	197,350,933	6.4%	13,487,258	11,362,736	-	428,292	54,118,076	59,374,864	59,920,349	167,409	(1,508,051)
Mental Hospital (> 65)	14,221,559	0.5%	14,317,519	42,101	-	98,666	-	-	-	-	(236,727)
Psychiatric Hospital (< 21)	16,462,790	0.5%	-	-	-	895	2,121,437	60,700	14,353,411	-	(73,653)
Physician	308,497,976	10.0%	25,584,421	14,358,794	-	537,212	69,492,976	90,674,791	109,748,875	1,151,266	(3,050,359)
Clinics	142,276,713	4.6%	3,938,310	4,132,776	-	271,090	41,107,698	35,058,269	58,306,470	150,951	(688,851)
Nursing Facility:											
Skilled Level	355,761,200	11.5%	309,345,906	144,783	-	1,282,902	45,579,574	162,364	563,941	90,495	(1,408,765)
Intermediate Level	322,671,839	10.4%	297,849,552	1,242	-	1,231,888	23,646,662	4,609	10,494	121,180	(193,788)
Intermediate Care Facility (Mentally Retarded)	339,722,311	11.0%	10,513,060	-	-	5,410,668	306,483,475	125,345	17,108,834	148,303	(67,374)
Dental	37,814,255	1.2%	3,475,652	2,950	-	76,139	7,281,728	10,542,767	16,395,870	90,748	(51,599)
Prescription Drugs	254,399,563	8.2%	91,456,597	-	-	1,165,395	90,786,807	31,857,203	39,560,205	62,949	(489,593)
Home Health	92,538,103	3.0%	11,924,109	207,679	-	630,996	48,607,279	4,765,069	26,705,653	1,566	(304,248)
CAP/Disabled Adult	67,698,625	2.2%	52,831,831	-		303,371	14,705,351	-	-	-	(141,928)
CAP/Mentally Retarded	26,084,842	0.8%	168,403	-		145,522	25,596,131	-	215,261	-	(40,475)
CAP/Children	1,995,879	0.1%	-	-	-	-	2,001,684	-	-	-	(5,805)
Personal Care	42,471,451	1.4%	28,314,009	-	-	801,808	12,435,367	546,160	484,624	-	(110,517)
Hospice	10,830,484	0.4%	5,019,902	-	-	48,986	5,466,870	322,705	111,344	-	(139,323)
EPSDT (Health Check)	22,514,207	0.7%	601	108	-	2,289	264,576	13,182	22,278,943	4,243	(49,735)
Lab & X-Ray	25,205,697	0.8%	1,614,536	1,194,202	-	55,620	7,604,164	9,379,119	5,416,980	31,340	(90,264)
Other Services	70,423,833	2.3%	5,394,398	1,071,960	-	82,401	7,520,763	19,400,678	36,993,272	53,425	(93,064)
Total Services	**2,951,231,801**	**95.5%**	**895,134,483**	**40,621,673***	**-**	**13,616,400**	**990,026,179**	**402,011,104**	**620,138,981**	**4,418,945**	**(14,735,964)**
Part A Premium	34,618,848	1.1%	33,099,498	538,429	-	523,796	18,445	261	-		438,419
Part B Premium	96,626,727	3.1%	46,028,544	29,774,284	3,372,963	456,518	16,111,156	560,974	17,956	4,765	299,567
HMO Premium	8,618,585	0.3%					-	2,499,384	6,119,181	-	-
Total Premiums	**139,864,140**		**79,128,042**	**30,312,713**	**3,372,963**	**980,314**	**16,129,601**	**3,060,619**	**6,137,137**	**4,765**	**737,986**
Grand Total and Premiums	**$ 3,091,095,941**		**974,262,525**	**70,934,386**	**3,372,963**	**14,596,714**	**1,006,155,780**	**405,071,723**	**626,276,118**	**4,423,710**	**(13,997,978)**

Note: Grand Total Expenditures do not include adjustments processed by DMA, settlements, Disproportionate Share Costs and State and County Administration costs.

* Reflects expenditures for those who were eligible as QMBs at the end of the year. As a result, expenditures include more services than are available through QMB coverage. (Medicare covered services only.)
** Includes SOBRA Pregnant Women.
*** Includes SOBRA Child and Other Other Child.

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Table 12
State Fiscal Year 1995
Expenditures For The Elderly

Type of Service	Aged	Percent of Service Dollars	MQBQ Qualified Medicare Beneficiary	MQBB Part B Premium Only	Total Qualified Beneficiaries	Percent of Service Dollars	Total Elderly Dollars	SFY 1995 % of Total Dollars	SFY 1994 % of Total Dollars	SFY 1993 % of Total Dollars
Inpatient Hospital	$ 19,898,419	2.0%	$ 8,102,342	$ -	$ 8,102,342	10.9%	$ 28,000,761	2.7%	3.8%	4.4%
Outpatient Hospital	13,487,258	1.4%	11,362,736	-	11,362,736	15.3%	24,849,994	2.4%	2.7%	2.3%
Mental Hospital (>65)	14,317,519	1.5%	42,101	-	42,101	0.1%	14,359,620	1.4%	1.5%	1.6%
Physician	25,584,421	2.6%	14,358,794	-	14,358,794	19.3%	39,943,215	3.8%	4.0%	3.6%
Clinics	3,938,310	0.4%	4,132,776	-	4,132,776	5.6%	8,071,086	0.8%	0.8%	0.7%
Nursing Facility:										
Skilled Level:	309,345,906	31.8%	144,783	-	144,783	0.2%	309,490,689	29.5%	32.8%	30.2%
Intermediate Level:	297,849,552	30.6%	1,242	-	1,242	0.0%	297,850,794	28.4%	33.3%	29.4%
Intermediate Care Facility-Mentally Retarded	10,513,060	1.1%	-	-	-	0.0%	10,513,060	1.0%	1.1%	0.9%
Dental	3,475,652	0.4%	2,950	-	2,950	0.0%	3,478,602	0.3%	0.3%	0.3%
Prescription Drugs	91,456,597	9.4%	-	-	-	0.0%	91,456,597	8.7%	8.9%	8.3%
Home Health	11,924,109	1.2%	207,679	-	207,679	0.3%	12,131,788	1.2%	1.1%	1.1%
CAP/Disabled Adult	52,831,831	5.4%	-	-	-	0.0%	52,831,831	5.0%	5.2%	4.3%
CAP/Mentally Retarded	168,403	0.0%	-	-	-	0.0%	168,403	0.0%	0.0%	0.0%
Personal Care	28,314,009	2.9%	-	-	-	0.0%	28,314,009	2.7%	2.9%	2.8%
Hospice	5,019,902	0.5%	-	-	-	0.0%	5,019,902	0.5%	0.5%	0.3%
EPSDT (Health Check)	601	0.0%	108	-	108	0.0%	709	0.0%	0.0%	0.0%
Lab & X-Ray	1,614,536	0.2%	1,194,202	-	1,194,202	1.6%	2,808,738	0.3%	0.3%	0.3%
Other Services	5,394,398	0.6%	1,071,960	-	1,071,960	1.4%	6,466,358	0.6%	0.6%	0.4%
Service Expenditures	**$ 895,134,483**	91.9%	**40,621,673**	-	**40,621,673**	54.7%	**935,756,156**	89.2%	100%	91%
Part A Premium	33,099,498	3.4%	538,429	-	538,429	0.7%	33,637,927	3.2%	6.0%	2.6%
Part B Premium	46,028,544	4.7%	29,774,284	3,372,963	33,147,247	44.6%	79,175,791	7.6%	0.6%	0.5%
HMO Premium		0.0%		-	-	0.0%	-	0.0%	0.0%	0.0%
Total Premiums	**$ 79,128,042**	100%	**30,312,713**	**3,372,963**	**33,685,676**	100%	**112,813,718**			
Total Service & Premium	**$ 974,262,525**		**70,934,386**	**3,372,963**	**74,307,349**		**1,048,569,874**			
Total Elderly Recipients	98,086		70,336	8,648	78,984		177,070			
Service Expenditures Per Recipient *	**$ 9,933**		**$ 1,009**	**$ 390**	**$ 941**		**$ 5,922**			

* Service Expenditure/Recipient amounts do not contain adjustments, settlements or administrative costs.
Source: SFY 1995 Program Expenditure Report and 2082 Report

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Table 13
State Fiscal Year 1995
Expenditures for the Disabled & Blind

Type of Service	Disabled	Percent of Service Dollars	Blind	Percent of Service Dollars	Total Blind & Disabled Dollars	SFY 1995 % of Total Dollars	SFY 1994 % of Total Dollars	SFY 1993 % of Total Dollars
Inpatient Hospital	$ 225,205,561	22.4%	$ 1,042,260	7.1%	$ 226,247,821	22.2%	22.0%	23.6%
Outpatient Hospital	54,118,076	5.4%	428,292	2.9%	54,546,368	5.3%	5.0%	4.7%
Psychiatric Hospital (>65)	-	0.0%	98,666	0.7%	98,666	0.0%	0.0%	0.0%
Psychiatric Hospital (<21)	2,121,437	0.2%	895	0.0%	2,122,332	0.2%	0.2%	0.2%
Physician	69,492,976	6.9%	537,212	3.7%	70,030,188	6.9%	6.5%	6.5%
Clinics	41,107,698	4.1%	271,090	1.9%	41,378,788	4.1%	3.0%	3.0%
Nursing Facility:								
Skilled Level:	45,579,574	4.5%	1,282,902	8.8%	46,862,476	4.6%	5.0%	5.0%
Intermediate Level:	23,646,662	2.4%	1,231,888	8.4%	24,878,550	2.4%	2.8%	2.8%
Intermediate Care Facility-Mentally Retarded	306,483,475	30.5%	5,410,668	37.1%	311,894,143	30.6%	33.9%	33.9%
Dental	7,281,728	0.7%	76,139	0.5%	7,357,867	0.7%	0.7%	0.7%
Prescription Drugs	90,786,807	9.0%	1,165,395	8.0%	91,952,202	9.0%	8.2%	7.7%
Home Health	48,607,279	4.8%	630,996	4.3%	49,238,275	4.8%	4.3%	4.2%
CAP/Disabled Adult	14,705,351	1.5%	303,371	2.1%	15,008,722	1.5%	1.4%	1.4%
CAP/Children	25,596,131	2.5%	145,522	1.0%	25,741,653	2.5%	0.2%	0.2%
CAP/Mentally Retarded	2,001,684	0.2%	-	0.0%	2,001,684	0.2%	2.3%	2.0%
Personal Care	12,435,367	1.2%	801,808	5.5%	13,237,175	1.3%	1.4%	1.3%
Hospice	5,466,870	0.5%	48,986	0.3%	5,515,856	0.5%	0.5%	0.5%
EPSDT	264,576	0.0%	2,289		266,865	0.0%	0.0%	0.0%
Lab & X-Ray	7,604,164	0.8%	55,620	0.4%	7,659,784	0.8%	0.8%	1.0%
Other Services	7,520,763	0.7%	82,401	0.6%	7,603,164	0.7%	0.6%	0.4%
Part A Premium	18,445	0.0%	523,796	3.6%	542,241	0.1%		
Part B Premium	16,111,156	1.6%	456,518	3.1%	16,567,674	1.6%		
HMO Premium	-	0.0%	-	0.0%	-	0.0%		
Total Service & Premiums	**$ 1,006,155,780**		**$ 14,596,714**		**$ 1,020,752,494**			
Number of Disabled/Blind Recipients	116,585		1,318		117,903			
Service Expenditures Per Recipient*	**$ 8,630**		**$ 11,075**		**$ 8,658**			

* Service Expenditures/Recipient does not include adjustments, settlements and administrative costs.

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Table 14
State Fiscal Year 1995
Expenditures for Families and Children

Type of Service	AFDC Adults	% of Service Dollars	Special Pregnant Women	% of Service Dollars	AFDC Children & Other Children	% of Service Dollars	Indigent Children	% of Service Dollars	Total Families & Children Dollars	SFY 1995 % of Total Dollars	SFY 1994 % of Total Dollars	SFY 1993 % of Total Dollars
Inpatient Hospital	$ 97,754,721	33.9%	$41,968,558	35.9%	$115,283,407	29.4%	$ 96,681,048	41.3%	$ 351,687,734	34.1%	36.0%	38.7%
Outpatient Hospital	46,967,989	16.3%	12,406,875	10.6%	39,748,202	10.1%	20,172,147	8.6%	119,295,213	11.6%	11.6%	11.8%
Psychiatric Hospital (<21	-	0.0%	60,700	0.1%	12,443,393	3.2%	1,910,018	0.8%	14,414,111	1.4%	1.7%	2.3%
Physician	58,487,936	20.3%	32,186,855	27.5%	66,927,727	17.1%	42,821,148	18.3%	200,423,666	19.4%	19.4%	19.6%
Clinics	15,499,804	5.4%	16,724,136	14.3%	42,322,817	10.8%	15,983,653	6.8%	90,530,410	8.8%	7.7%	6.8%
Nursing Facility:												
Skilled Level:	162,364	0.1%	-	0.0%	519,086	0.1%	44,855	0.0%	726,305	0.1%	0.1%	0.1%
Intermediate Level:	4,609	0.0%	-	0.0%	10,494	0.0%	-	0.0%	15,103	0.0%	0.0%	0.0%
Intermediate Care Facility-												
Mentally Retarded	125,345	0.0%	-	0.0%	15,755,395	4.0%	1,353,439	0.6%	17,234,179	1.7%	2.7%	2.5%
Dental	10,157,476	3.5%	385,291	0.3%	11,737,278	3.0%	4,658,592	2.0%	26,938,637	2.6%	2.8%	2.9%
Prescription Drugs	29,364,934	10.2%	2,492,269	2.1%	24,487,384	6.2%	15,072,821	6.4%	71,417,408	6.9%	6.8%	6.5%
Home Health	4,084,704	1.4%	680,365	0.6%	13,554,831	3.5%	13,150,822	5.6%	31,470,722	3.1%	3.2%	2.9%
CAP/Disabled	-		-		-		-					
CAP/Mentally Retarded	-		-		207,722	0.1%	7,539					
CAP/Children	-	0.0%	-	0.0%	30,801	0.0%	-	0.0%	30,801	0.0%	0.0%	0.0%
Personal Care	533,598	0.2%	12,562	0.0%	225,277	0.1%	259,347	0.1%	1,030,784	0.1%	0.0%	0.0%
Hospice	322,705	0.1%	-	0.0%	51,478	0.0%	59,866	0.0%	434,049	0.0%	0.0%	0.0%
Health Check - EPSDT	1,018	0.0%	12,164	0.0%	11,298,484	2.9%	10,980,459	4.7%	22,292,125	2.2%	0.0%	1.3%
Lab & X-Ray	6,521,206	2.3%	2,857,911	2.4%	3,932,639	1.0%	1,484,341	0.6%	14,796,097	1.4%	1.4%	1.5%
Other Services	15,190,997	5.3%	7,044,013	6.0%	27,828,118	7.1%	9,165,154	3.9%	59,228,282	5.7%	6.4%	3.3%
Part A Premium	261	0.0%	-	0.0%	-	0.0%	-	0.0%	261	0.0%		
Part B Premium	535,441	0.2%	25,533	0.0%	7,800	0.0%	10,156	0.0%	578,930	0.1%		
HMO Premium	2,499,384	0.9%	-	0.0%	6,119,181	1.6%	-	0.0%	8,618,565	0.8%		
Total Service & Premiu	**$ 288,214,492**		**116,857,232**		**392,491,514**		**233,815,405**		**1,031,163,382**			
Number of Family & Child Recipients	180,941		66,390		337,117		195,447		779,895			
Service Expenditures Per Recipient*	$ 1,593		$ 1,760		$ 1,164		$ 1,196		$ 1,322			

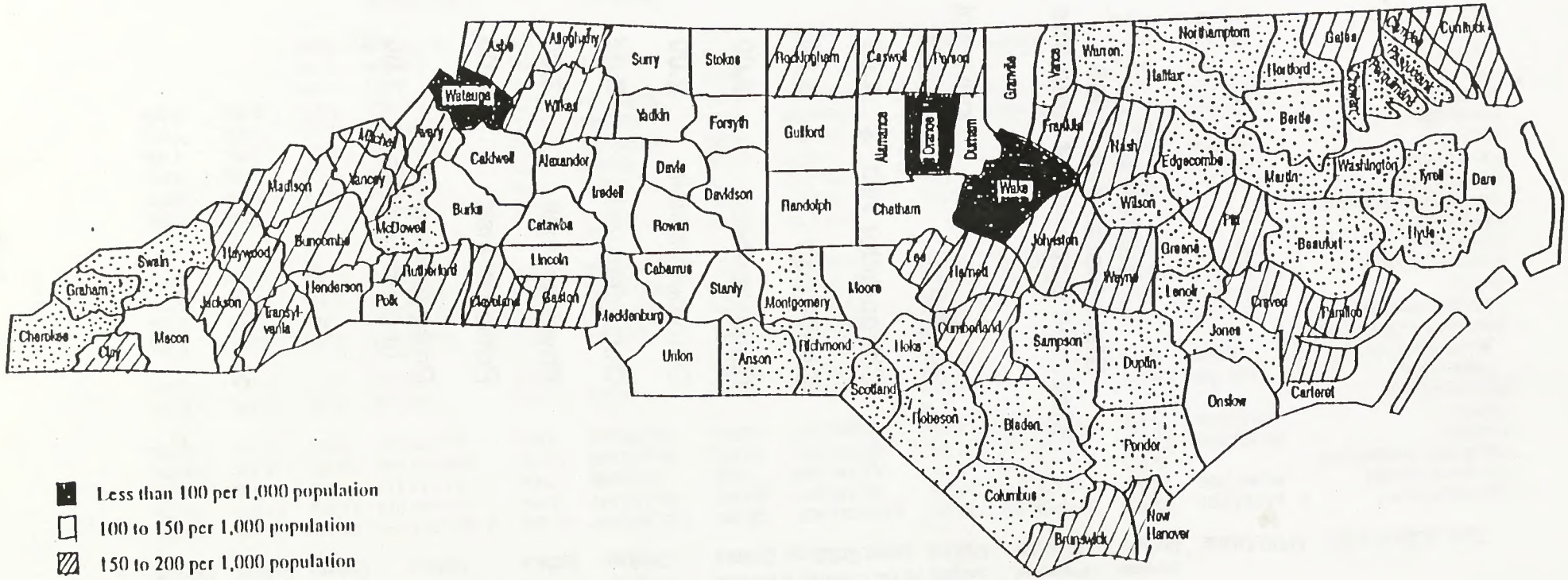
* Service Expenditures per Recipient does not include adjustments, settlements, and administrative costs.

Source: SFY 1995 Program Expenditure Report & 2082 Report

Table 15
State Fiscal Year 1995
Medicaid Copayment Amounts

Service	Copayment Amount
Chiropractor visit	$ 1.00
Dental visit	3.00
Optical service	2.00
Optometrist visit	2.00
Outpatient visit	3.00
Physician visit	3.00
Podiatrist visit	1.00
Prescription drug (including refills	1.00

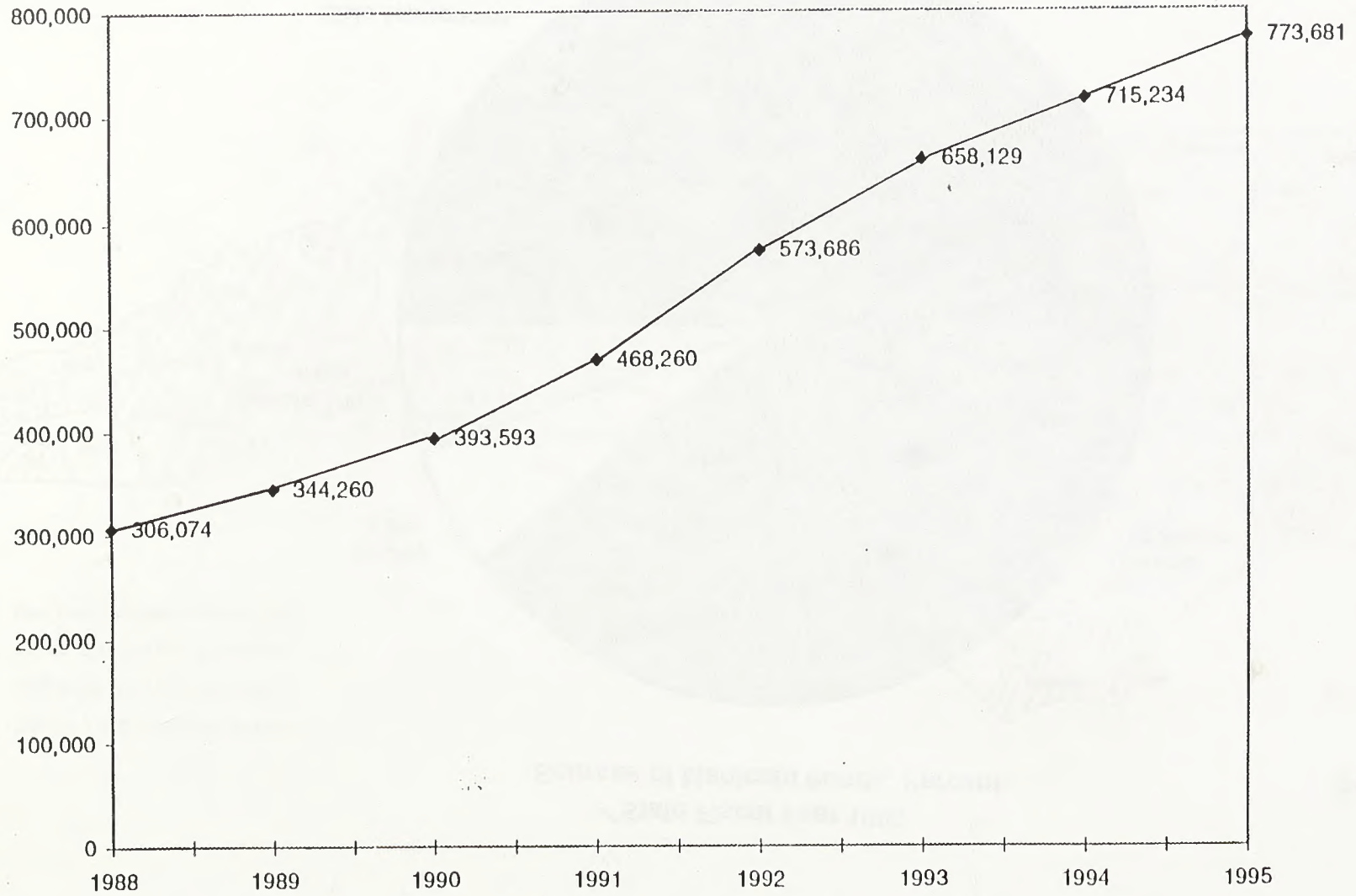
State Fiscal Year 1995
Eligibles per 1,000 Population



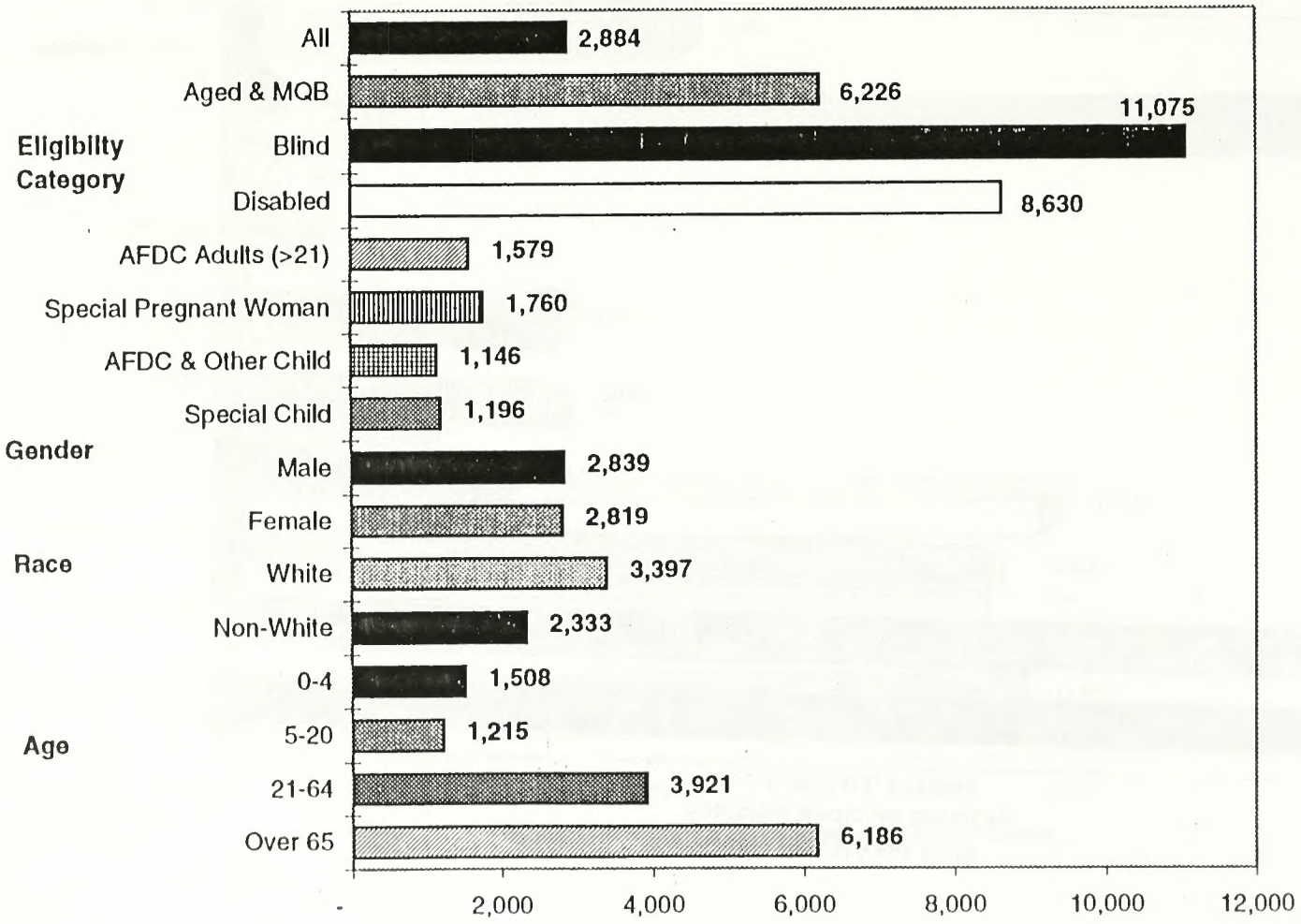
- Less than 100 per 1,000 population
- 100 to 150 per 1,000 population
- 150 to 200 per 1,000 population
- 200 per 1,000 population and above

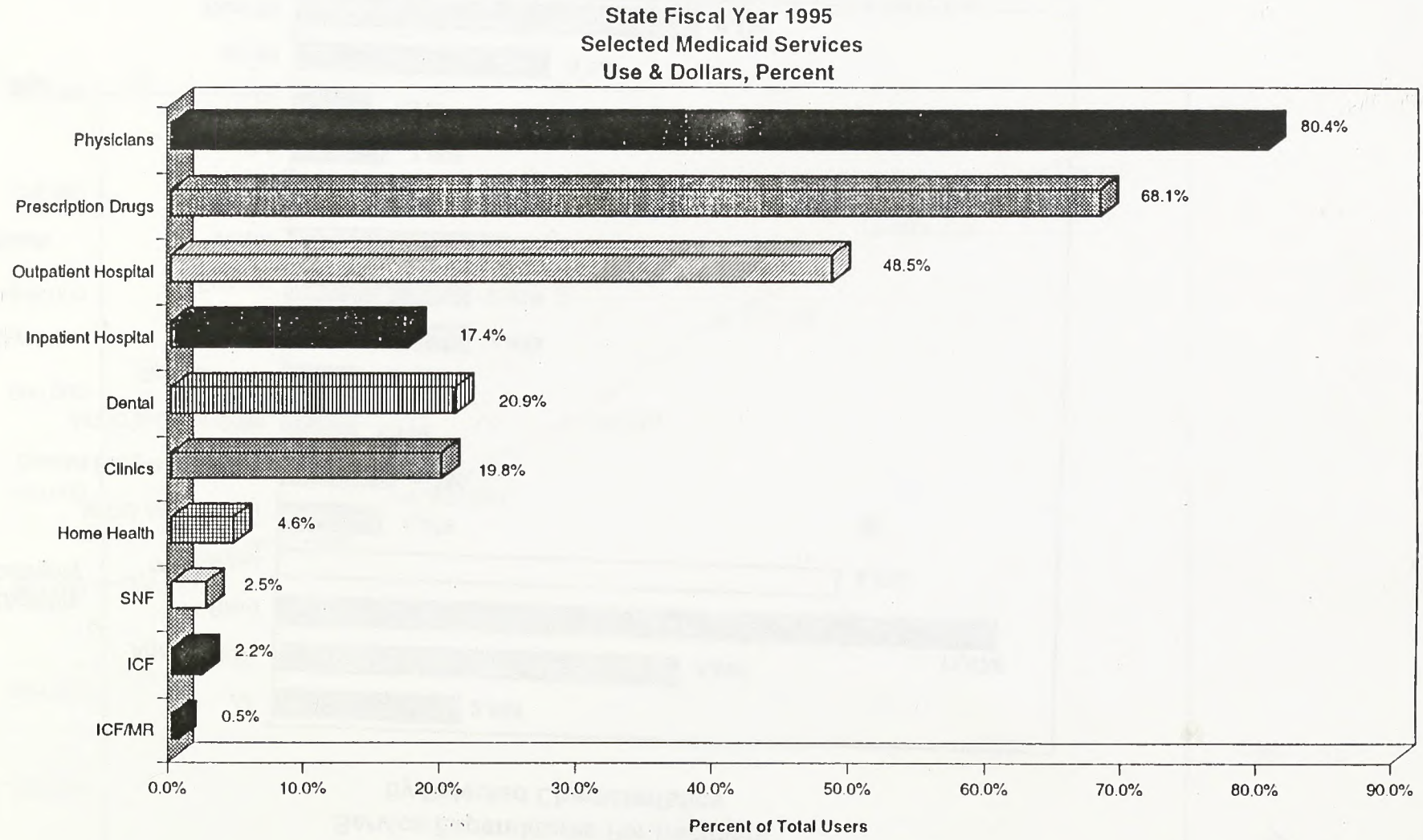
State Fiscal Year 1995
Sources of Medicaid Funds, Percent

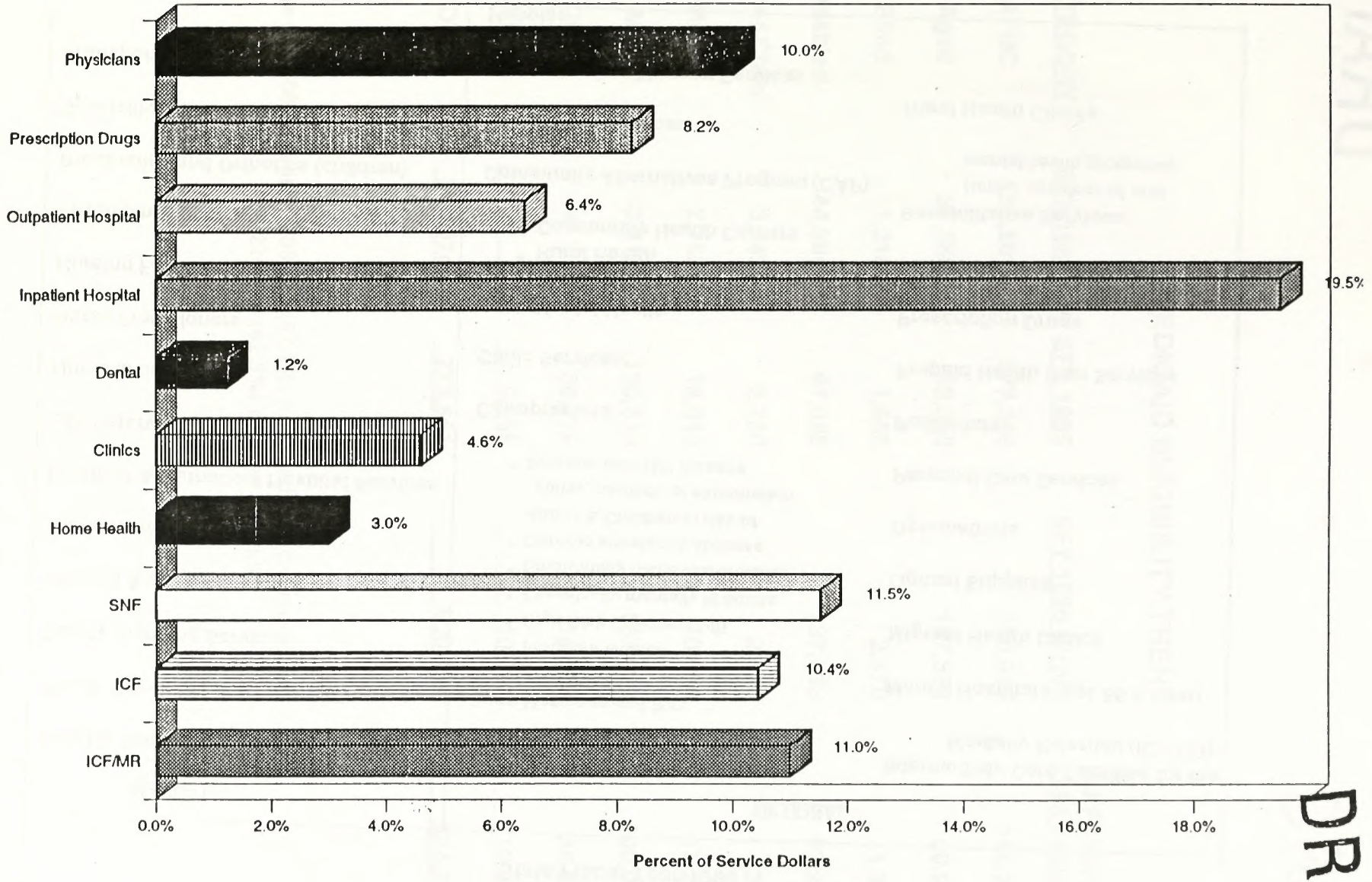
A HISTORY OF MEDICAID ELIGIBLES



State Fiscal Year 1995
Service Expenditures Per Recipient
by Selected Characteristics




State Fiscal Year 1995
Selected Medicaid Services
Use & Dollars, Percent
Physicians
Prescription Drugs
Outpatient Hospital
Inpatient Hospital
Dental
Clinics
Home Health
SNF
ICF
ICF/MR
80.4%
68.1%
48.5%
17.4%
20.9%
19.8%
4.6%
2.5%
2.2%
0.5%
0.0%
10.0%
20.0%
30.0%
40.0%
50.0%
60.0%
70.0%
80.0%
90.0%
Percent of Total Users


Physicians
10.0%
Prescription Drugs
8.2%
Outpatient Hospital
6.4%
Inpatient Hospital
19.5%
Dental
1.2%
Clinics
4.6%
Home Health
3.0%
SNF
11.5%
ICF
10.4%
ICF/MR
11.0%
0.0%
2.0%
4.0%
6.0%
8.0%
10.0%
12.0%
14.0%
16.0%
18.0%
Percent of Service Dollars

Medicaid Services
State Fiscal Year 1995

MANDATORY

Durable Medical Equipment

Health Check Services (EPSDT)

Family Planning Services

Hearing Aids (for children)

Home Health Services

Inpatient & Outpatient Hospital Services

Laboratory & X-Ray Services

Nurse Midwives

Nurse Practitioners

Nursing Facilities (NF)

Physicians

Prosthetics and Orthotics (children)

Speciality Hospitals

Transportation

OPTIONAL

Ambulance Transportation

Case Management for:

* Pregnant women
* High Risk Children (0-5)
* Chronically mentally ill adults
* Emotionally disturbed children
* Chronic substance abusers
* Adults & Children at risk of abuse, neglect, or exploitation
* Persons with HIV disease

Chiropractors

Clinic Services:

* Mental Health
* Public Health
* Rural Health
* Community Health Centers

Community Alternatives Program (CAP)

Dental Care Services

Home Infusion Therapy Services

Hospice

Intermediate Care Facilities for the Mentally Retarded (ICF-MR)

Mental Hospitals (age 65 & over)

Migrant Health Clinics

Optical Supplies

Optometrists

Personal Care Services

Podiatrists

Prepaid Health Plan Services

Prescription Drugs

Private Duty Nursing Services

Rehabilitative Services: (under auspices of area mental health programs)

Rural Health Clinics

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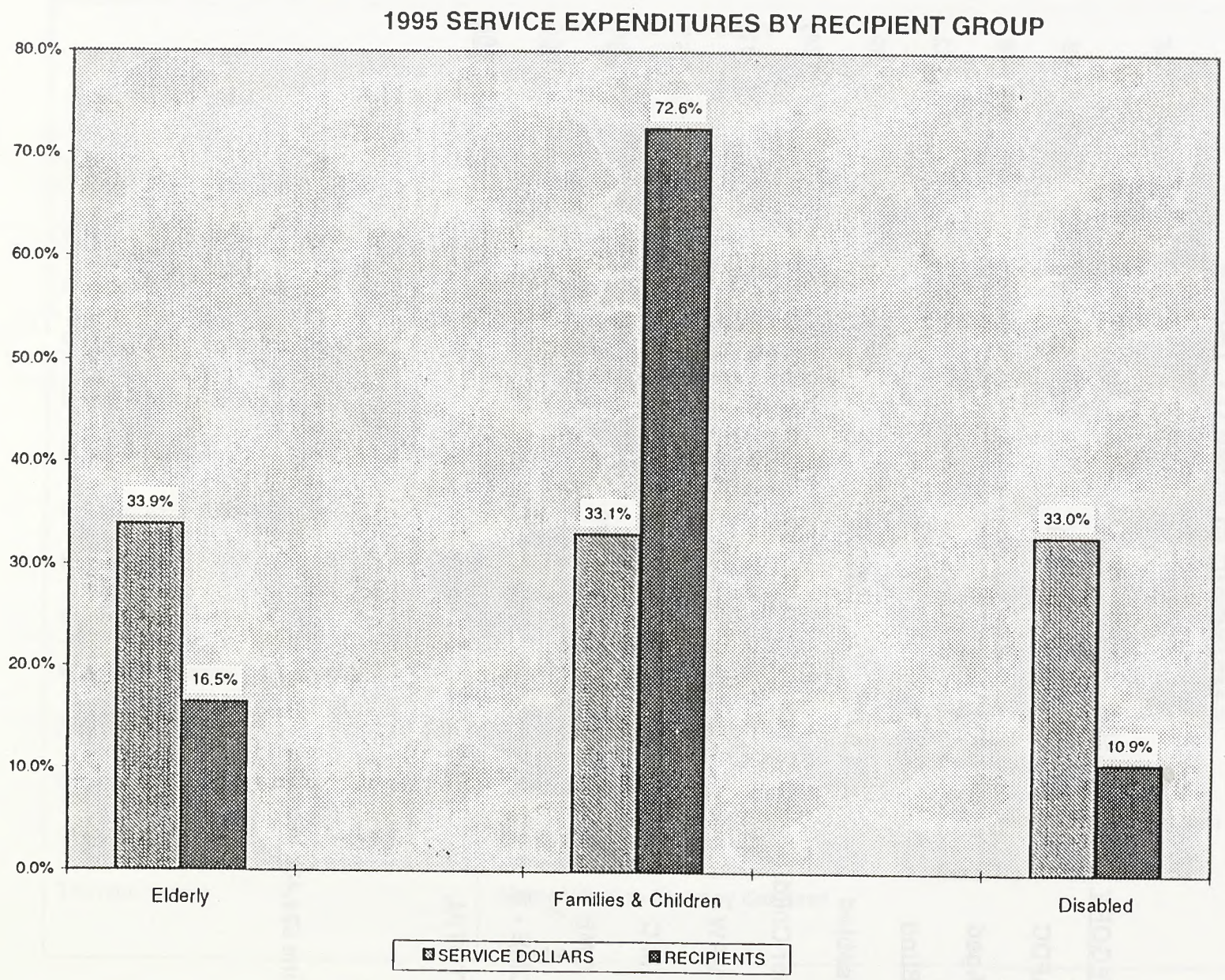
MEDICAID ELIGIBILITY TREND

CATEGORY	SFY 1988	SFY 1995	SFY 1996 (Proj.)	DIFFERENCE 1988 - 1996
AFDC	195,561	377,349	350,960	155,399
Aged	56,380	83,360	107,358	50,978
Blind	1,218	1,662	2,570	1,352
Disabled	44,994	97,065	137,233	92,239
Other Child	3,149	2,780	2,825	(324)
MPW	2,753	18,613	20,000	17,247
MIC	2,019	130,819	163,000	160,981
QMB	0	56,778	36,536	36,536
QMB - B	0	5,255	10,000	10,000
TOTAL	306,074	773,681	830,482	524,408

Of the 524,408 increase: 299,644 (57.1%) are Aged, Blind, Disabled, or AFDC,
224,764 (42.9%) are new groups.


1995 SERVICE EXPENDITURES BY RECIPIENT GROUP
80.0%
70.0%
60.0%
50.0%
40.0%
30.0%
20.0%
10.0%
0.0%
33.9%
16.5%
33.1%
72.6%
33.0%
10.9%
Elderly
Families & Children
Disabled
SERVICE DOLLARS
RECIPIENTS

DRAFT

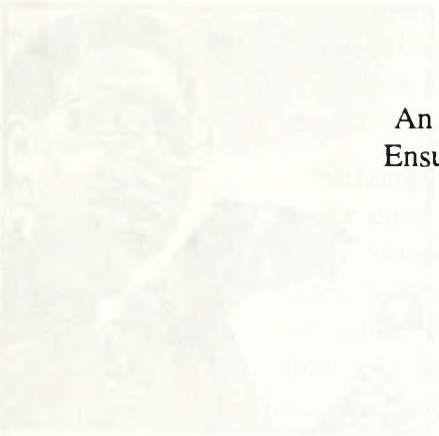
WHO CAN RECEIVE MEDICAID ?

AUTOMATIC COVERAGE	THOSE WHO MUST APPLY
AFDC	Medically Needy * AFDC Related
SSI * Aged * Blind * Disabled	* Aged * Blind * Disabled
SA (Rest Home)	MPW
	MIC
	MQB
	Foster Care & Adopted Children

RCV'D 4/15

Selected Medicaid Services as a Percentage of Total Expenditures
SFY 1995

Long Term Care	
ICF	10.4%
SNF	11.1%
ICF-MR	11.0%
All Home-Based Care	7.7%
All LTC	**40.2%**
Hospital	
Inpatient	18.6%
Mental Hospital	1.0%
Total Hospital	**19.6%**
Outpatient	
Clinics	4.2%
Emergency Room	2.1%
Other Hospital Outpatient	3.3%
Physician	8.5%
Total Outpatient	**18.1%**
Pharmacy	8.2%
Dental	1.2%
Medicare	7.4%
All Other Services	5.3%



Appendix H

An Allied Health Workforce for the 21st Century
Ensuring Access and Quality for North Carolinians
Executive Summary

The Allied Health Crisis in North Carolina

1994-1995

An Allied Health Workforce for the 21st Century

Ensuring Access and Quality for North Carolinians

Executive Summary

This document summarizes the issues, needs, priorities and recommendations related to developing an allied health workforce to meet North Carolina's needs in the 21st century.

The Council for Allied Health in North Carolina

The Allied Health Crisis in North Carolina

Today in North Carolina there are children who urgently need speech and language therapy but are unable to receive those services due to a statewide shortage of speech/language pathologists. Elderly patients in nursing homes are waiting for physical therapy to restore lost functioning and reduce pain —but the shortage of physical therapists is critical. Persons with disabling conditions require occupational therapy to remain independent in their own homes, yet the professionals to provide those services are very scarce. Shortages in these three fields have reached a crisis stage.

THE COUNCI FOR ALLIED HEALTH IN NORTH CAROLINA

Eugene S. Mayer, M.D., Chair

Every day, we depend on the services of allied health professionals.These include physician assistants who provide primary health care to rural residents, radiologic technologists who perform mammograms to detect breast cancer, clinical laboratory technologists who conduct tests for prostate cancer, and medical sonographers who generate images of the developing fetus.

Allied health services are threatened by shortages of qualified personnel. Hospitals, nursing homes, home care agencies, public health departments and schools all report they are not able to fill hundreds of such positions. At the same time many qualified applicants to schools of allied health must be turned away due to lack of space, because our education program capacity has lagged behind the need for services. This situation makes for a less productive healthcare workforce, raises costs, and deprives people of rewarding careers.

Although the various parties have not always agreed on proposed solutions to the allied health personnel shortage, they have found substantial common ground in developing recommendations for alleviating it. While these recommendations will not solve the problem entirely, we believe that they are workable and can be implemented at a modest cost. The following pages briefly summarize the scope of the problem, our recommendations for solving it, and information on the Council for Allied Health in North Carolina.

The Council for Allied Health in North Carolina member organiza

Employers

- NC Health Care Facilities Association
- NC Hospital Association
- NC Division of Mental Health, Developmental Disabilities and Substance Abuse Services,
- NC Department of Human Resources
- NC Office of Rural Health and Resource Development
- NC Department of Public Instruction
- NC Association for Home Care
- NC Department of Environment, Health and Natural Resources

Allied Health Associations

- NC Physical Therapy Association
- NC Occupational Therapy Association
- NC Speech, Hearing and Language Association
- NC Rehabilitation Counselor's Association
- NC Society of Hospital Social Work Directors
- NC Recreation Therapy Association
- NC State Society of American Medical Technologis
- NC Society for Clinical Laboratory Science
- NC Association of Blood Bankers
- Blue Ridge Chapter, Clinical Laboratory Manageme Association
- Coastal Chapter, Clinical Laboratory Management Association

Summary of Recommendations

Educational Programs

1 .Expand enrollments in three discipline areas in public university allied health programs, namely:

- **Occupational therapy** programs at East Carolina University, UNC-Chapel Hill and Winston-Salem State University.
- **Physical therapy** programs at East Carolina University,UNC-Chapel Hill, Winston-Salem State University and Western Carolina University.
- **Speech/language pathology** programs at Appalachian State University, East Carolina University, North Carolina Central University, UNC-Chapel Hill, UNC-Greensboro, and Western Carolina University.

2. Strengthen existing community college programs which prepare Occupational Therapy Assistants and Physical Therapist Assistants and provide start-up funds for one OTA program.

3. Support legislation to establish the "Communication Assistant" category of support personnel for speech/language pathologists, establish three training programs by 1997 and an additional four programs by 1999.

4. Strengthen all allied health programs at campuses of the University of North Carolina and the Community College System; provide faculty development and upgraded technology and equipment.

5. Determine the need for up to two programs to train Physician Assistants at campuses of the University of North Carolina, with a particular focus on primary care services to underserved populations.

6. Establish a "matching fund" to assist with the start-up of community college programs in allied health.

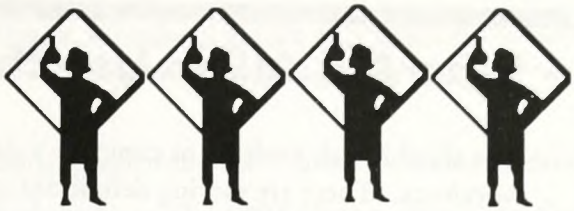
7. Strengthen educational opportunities for mid-career allied health practitioners through the cooperative efforts of the University of North Carolina, (including its AHEC Program) and the Department of Community Colleges.

8. Improve recruitment of minorities into allied health careers . Continue the cooperative efforts of the nine AHEC Centers and the NC Health Careers Access Program with state support.

ns are:

NC Section, American Association of Clinical Chemists
NC Society of Cytology
Eastern NC Clinical Laboratory Management Association
NC Society of Histopathology Technologists
American Society of Phlebotomy Technicians
NC State Advisor, American Society of Clinical Pathologists, Associate Member Services
Southeastern Association of Clinical Microbiology
NC Nuclear Medicine Society
NC Society of Radiologic Technologists
NC Society for Respiratory Care
NC Ultrasound Society

NC Academy of Physician Assistants
NC Dietetic Association
NC Dental Hygienists Association
NC Dental Assistants Association
NC Health Information Management Association
NC Society of Medical Assistants



Employment and Recruitment

9. Employers should participate in the development of allied health manpower resources by:

- supporting educational programs and allied health students training;
- providing adequate compensation for allied health personnel through salaries, opportunities for advancement, educational opportunities and benefits;
- cooperating with other regional agencies or employers in recruitment practices when personnel and resources are scarce; and
- implementing outreach efforts to encourage young people to enter allied health careers, with careful attention to the need for racial and cultural diversity among the professional groups.

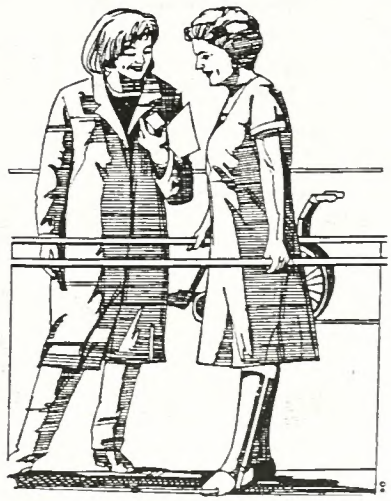
Information and Communication for Policy Development

10. The state should establish an Allied Health Information Management System under the stewardship of the North Carolina AHEC Program, to include: information on the statewide demand for and the production and supply of trained personnel, and a mechanism for tracking allied health personnel who enter the workforce.

11. The Council for Allied Health should continue to serve as a resource for all whose decisions affect access to allied health care in our state. The state should provide funding to the North Carolina AHEC Program to manage the operation of the Council.

Education Programs

University of North Carolina General Administration
UNC Allied Health Education Programs
NC Department of Community Colleges
Community College Allied Health Programs
NC Area Health Education Centers (AHEC) Program
AHEC Allied Health Education Coordinators



Who Are Allied Health Professionals?

The allied health professions comprise a sizeable sector of the health care workforce. There are varying definitions of "allied health," but in general they can be categorized as those health professions associated with diagnostic, therapeutic, preventive and administrative functions. They are to be found in all health care settings as well as many education and rehabilitation facilities.

For the purposes of its work, the Council for Allied Health considers "Allied Health" to include the following professions:

- Clinical Laboratory Scientists, also called Medical Technologists, and laboratory specialists, such as Cytotechnologists, Blood Banking Specialists, Histopathology Technicians, and Phlebotomists
- Dietitians
- Dental Hygienists* and Dental Assistants
- Health Information Managers (also termed Medical Record Administrators)
- Medical Assistants
- Medical Social Workers
- Occupational Therapists* and Occupational Therapy Assistants*
- Physical Therapists* and Physical Therapist Assistants*
- Physician Assistants*
- Radiologic Technologists and specialists, Nuclear Medicine, Medical Sonography, Radiation Therapy Technology and "Imaging Specialties"
- Recreation Therapists
- Rehabilitation Counselors
- Respiratory Therapists and Technicians
- Speech Language Pathologists* and Audiologists*

*State licensed personnel

What is the Council for Allied Health in North Carolina?

The Council for Allied Health in North Carolina was established as a formal organization in 1991. The Council is unique in the state, and perhaps in the nation, as an entity that is balanced to bring together:

1) **employers**,

2) **educational organizations** and

3) **allied health professional associations**.

The goals of the Council are:

- **to monitor allied health workforce trends in North Carolina;**
- **to be a forum for information and issues relating to the education, recruitment and retention of allied health personnel; and**
- **to develop and recommend strategies to improve access to allied health services, and to monitor the implementations of those strategies.**

The entire report, An Allied Health Workforce for the 21st Century, contains extensive information on the state of the allied health care professions in North Carolina today. The report also contains:

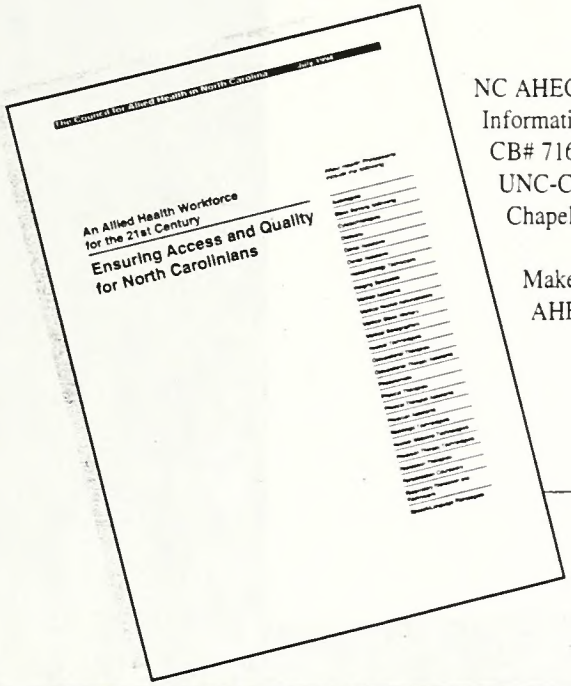
(1) detailed cost estimates for implementing the Council's recommendations;

(2) the Executive Summary of the Council's ***1993 Human Resources Survey***, which contains data on staff positions, vacancies, salaries, and recruitment for allied health occupations across all employment and geographic sectors of the state (Appendix II) ; and

(3) a full description of the Council's proposed ***Allied Health Information Management System*** (Appendix III).

North Carolina is the first state to boast a group such as the Council and to have produced an authoritative, data-based report on this important topic. Not only will the report add to knowledge about allied health, it should be a significant contribution to the work that is being done on health care reform in general.

If you would like to order a copy of the full report, please send a check for $5.00 made payable to the "North Carolina AHEC Program" to the following address:



NC AHEC Program
Information & Publications Office
CB# 7165, Wing C, School of Medicine
UNC-Chapel Hill
Chapel Hill NC 27599-7165

Make check payable to "North Carolina AHEC Program."

The Council for Allied Health in North Carolina

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